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TWO MAIN TYPES OF NERVOUS TROUBLE*

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Tonight I want to share with you some of the most helpful of the many helpful ideas that I have picked up in some fifty years of practice.

HOW I CAME TO BECOME ACQUAINTED WITH MANY QUEER SYNDROMES

As you know, for twenty-five years I sat at a sort of medical crossroads in Rochester, Minnesota, where daily I saw people with weird syndromes, many of them not described in books. Often the home doctor had suspected a neurosis, but he wasn't sure because he did not know the syndrome that the patient presented, and then granting that the disease was a neurosis, the question remained, why did the patient suffer from it?

Often when asked about nervousness the patient protested that there was nothing difficult in his life; he was successful, he had a good wife, he had lovely children, enough money, and a nice home. He felt it couldn't be a neurosis; it must be something organic.

Eventually I saw so many of these odd people that I came to recognize the syndromes of many

of them in a few minutes. Their disease was like the face of an old friend, and that is my excuse for talking to you about these people tonight: I know them well.

Another excuse I have for talking with you about these people is that I have found that their disease is fairly common. Certainly in a consultant medical practice one can see any number of these patients every week.

A TYPICAL CASE OF "NERVES PLAYING TRICKS"

Following is an example of the type of case that I often see: the patient was a brilliant, over-emotional South American lawyer, an ambassador to France, 45 years of age. He said that on sitting down to eat, or on taking a little food he suddenly would become terribly jittery; he might become short of breath, he would get palpitation, his heart would start missing beats, he would get a terribly tight feeling in his head, he would feel he was going insane, he would get numb all over, his tongue would feel queer or too big or thick. He would develop a globus, he might sweat all over; he might get a nervous chill; he might get a feeling of pins and needles all over his body;

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he might get nauseated; he might start belching and salivating. He would then fear he was going to have a loose bowel movement; he would run to the toilet but usually his bowels did not move. Because he was so afraid of these spells he avoided eating, and naturally became very thin.

As this man said, he had seen some of the leading medical consultants in Paris and London and New York; most of them realized that his autonomic nerves were playing tricks with him; they were playing tricks with his heart, his digestive tract, his bowel, his sweat glands and the muscles in his skin. But the question still remained why was he suffering in this way? Why also did this "storm" practically always come at mealtime? And why had this trouble picked on him?

Let us see first why the spells came at mealtime. All of you know that some of us when we eat can develop reflexes which can be distressing, as when a man after dinner goes to sleep in front of his guests, and snores. Sleepiness is one of the reflexes that can follow eating. Another reflex which I myself have occasionally when I drink something warm, causes me to feel hot and to perspire freely. I do this only when I am very tired or when I have a cold which apparently has keyed up my reflexes.

EXAGGERATED REFLEXES AND EXAGGERATED SENSITIVENESS

Did this man have exaggerated reflexes? He certainly did. When I touched his patellar tendon with my hammer not only did the leg fly up but the other one did too, showing how tremendously on edge he was.

Then I found that his intestinal reflexes were greatly exaggerated. For instance if he drank a glass of ice water it would apparently shoot down into his jejunum and there produce a violent dumping syndrome. Knowing well the peculiarities of the man with reflexes like that I asked him if he could take an enema and he said "Oh, no! It produces great distress; I feel a terrible burning all through my abdomen; I get nauseated, and sometimes I will even vomit."

To show my assistants how sensitive such a patient can be, I asked one of them to check his inguinal rings, but this the man could not permit. He said it hurt him too much. Similarly when an assistant tried to make a digital examination of the man's rectum he couldn't stand it: he said it hurt terribly.

Often in these cases if I want to be sure about the degree of sensitiveness of the patient I send him to my friend the rectal specialist for a proctoscopic examination. Soon the patient comes back complaining bitterly that the pain was terrific and he could not stand it. Actually I have had the instrument passed on me several times, and although I am sensitive I did not feel pain. The reason these people call the distress pain is because they are so abnormally sensitive.

On talking to the man I found that he had always been hypersensitive; apparently he was born that way. Even as a child he could easily get jittery with any excitement. I feel sure that these people inherit this type of a nervous system. Why do I feel so sure of this? Because I have so commonly found hypersensitiveness in member after member of a highly nervous family.

THE MAN'S PSYCHOTIC RELATIVES

The next question then was from which relatives did the man get his hypersensitiveness? I asked him first if any of his relatives were flighty or eccentric or difficult, or if any one had had a sorrow and had broken nervously. If I had asked bluntly who in the family was insane he would probably have said "No one." To my question he replied, "Oh yes, I have a number of eccentrics in my family, but I have several worse than that. My mother, her brother and her sister all went insane and were committed. Moreover two of mother's brothers were such violent eccentrics that they did not dare go out of the house very often for fear they might get into an argument with someone and kill him. Also, I have several relatives whom we call just goofy."

Now this case will introduce you to the central

theme that I am going to present to you tonight. I have seen many hundreds of these people; in the last five years I have been abstracting their records and throwing the abstracts into a file. Recently on going over some 900 of these abstracts, I found that in 733 of them there was a note that the patient had had one or more relatives who were either psychotic or alcoholic or epileptic. Because of this tremendous incidence of mental disease in the families of these highly nervous and highly sensitive and over-reactive persons I believe that their difficulty is due to their poor nervous heredity.

HOW COMMON IS A POOR NERVOUS INHERITANCE?

Many of my friends to whom I have spoken of this finding have immediately countered with the statement that in any family if one searches hard enough one can find some insane relatives. This I feel sure is not true. In order to see if it was true, I questioned 100 persons who had come to the Mayo Clinic because of some organic trouble such as an old fracture that had to be re-broken and reset. In spite of the most careful questioning I could find only 4 who had psychotic relatives; I found 3 who had alcoholic relatives, and I found 1 who had had a psychopathic delinquent relative. The rest couldn't remember anyone in the family who had been mentally disturbed.

RESENTMENTS FELT BY PERSONS WHO HAVE INSANITY IN THE FAMILY

Other persons who heard of my findings in these cases tended to become a bit resentful or even angry at me. Unfortunately they had in their family an uncle or an aunt who was a bit queer or who was in a state hospital: because they did not want to inherit this defect, and they did not want their children to inherit it, they took great comfort in the present-day refusal of many men to accept the abundant evidence presented by geneticists to show that mental disease is inherited.

I tell my friends who are upset about such talk of heredity that there seems little sense in denying its obvious importance. I tell them I had one grandmother who, although often a very attractive person, at times was temperamental, and always cursed with a quick temper. I can see how her irritable nerves have been passed on down through my mother, to me and all of my sibs and my children. We all got a little dose of those nerves. If we could have inherited only the calm steady nerves of my father's people we would have had no trouble. But then perhaps we would have been quieter and less vivid and even less happy characters than we have been. We got a colorful personality from mother, and I think that was worth paying something for.

THE AUTONOMIC NERVOUS SYSTEM IS ERRATIC

But to get back to my patient, the ambassador; I felt satisfied that his nervous storms were just his share of the family's curse of bad nerves. My hunch was that while his ancestors had psychic troubles in the upper part of the brain, his may have been down in the hypothalamus or in some part of the brain that presides over the autonomic nerves. Certainly in thousands of these cases the autonomic nervous system is erratic in its behavior, and hence causes much distress.

CHARACTERISTICS OF THE RELATIVES OF THE PSYCHOTIC

Often these relatives of the psychotic are odd, eccentric, or peculiar persons. In the worst cases one can recognize in a moment the person with a pinched facies, perhaps ascetic looking, perhaps with piercing psychotic eyes. The minute one shakes hands one may feel a cold clammy hand, and one notices that the patient gives a peculiar shy hand shake with his eyes averted. Quickly he may pull his hand away as if he resented the human contact.

Other persons one will soon note are mentally slowed up; sometimes they tell their story so slowly and deliberately that one gets impatient,

and turns to the spouse to get the story. Such persons sometimes break down and weep in the office.

Then there are the persons whom my old assistants used to call "screwballs;" they obviously were born a bit odd. Sometimes the relative who comes in with the patient is also queer, and this fact helps in the diagnosis.

I'll never forget the lad who came up from the mountains of Tennessee. He was goofy and not very intelligent, but he was a sweet gentle fellow whom we liked. When it came time for him to go home we were so afraid to let him go by himself that we telegraphed his father to come and get him. The amusing thing was that when the father came, he was so much goofier than was the boy that we sent the father home in the care of the boy!

One evening in St. Louis I was talking about these queer people, and a doctor later came up to me and said, "You know, Alvarez, we have a lot of those funny people living down here on the mud flats. One of my patients happens to be a census taker and he was telling me how one day he went up to one of those shacks made out of boxes and tin cans; he knocked at the door, and out came a stupid-looking, slattern and goofy sort of a woman. Because he didn't have any hopes of getting much information out of her he asked if her father was home. She said, 'No, he's up in the state penitentiary.' 'Well,' he said, 'Is your mother home?' 'No, she's in the state hospital.' 'Well, have you a brother perhaps?' 'Yes, I got one, but he is in the reform school.' 'Well, have you an older sister perhaps that I could talk to?' 'Yes, I got one but she aint come home yet; she works over in the red light district.' 'Well,' said the census taker, 'perhaps you have another brother I could talk to.' 'Yes,' she said slowly, 'I got another brother but he is in the medical school at Harvard!' Astounded, the census taker asked, 'You don't mean to tell me that you've got a brother who's a doctor at Harvard?' 'No,' drawled the woman, 'he aint no doctor, he's got two heads; he's in a bottle of

alcohol!' " That's the sort of family that one sometimes runs up against as one starts questioning a queer psychotic patient with a misshapen body.

THE INABILITY OF SOME PATIENTS TO GIVE A LOGICAL HISTORY

As all of you old clinicians know, there are some patients who when they come in, quickly answer your questions, and give you all the history you need with which to make a diagnosis. For instance, a man with an ulcer will say right off that he has a pain in his epigastrium that comes at 11:00 in the morning and 5:00 in the afternoon, and gets him out of bed at 1:00 in the morning. He takes a little milk or a little soda and he's comfortable again.

In contrast to this type of patient, is a woman who when you ask her questions answers irrelevantly. For instance, one day I said to a woman, "What is your main trouble?" She said, "My uncle used to have a terrible constipation." I said, "No, let's get back to the question; I want to know what's the main trouble with you." She said, "My doctor gave me a green medicine; would you like to see it?" "No," said I, "let's get back to the question. What is your main symptom?" Her answer was, "I saw a woman down at the store and she said if you take this herb tea you will get better."

Just for fun sometimes I have kept asking a patient like that the same question for half an hour or so, just to see how she avoids answering it logically.

Years ago, Dr. T. A. Ross, the great psychiatrist of England, told me that he was sure these people were psychotic and usually schizophrenic. At that time I could hardly believe him, but today I do. A schizophrenic sometimes has something wrong with his brain which makes it impossible for him promptly to answer the question that is put to him. There seems to be too much of a lag in his understanding.

Curiously today, we have a drug which when injected into a volunteer will make him, for some

16 hours, like a schizophrenic. The remarkable thing is that during this time these people will answer questions in this crazy way. Their mental processes have been to some extent disintegrated.

THE PERSON WHO HAS HAD DEPRESSIONS

Often if one asks skillfully enough one can get a history of depressions which may have started in childhood and may have kept coming at intervals ever since. Often a woman will say that she had had two or three "nervous breakdowns." If one asks what the symptoms were she may say that she just sat and did nothing; she was not interested in anything; she felt terribly tired; she may have felt sinful and terribly discouraged; she may have felt that the family would be much better off if she committed suicide.

The important thing to remember about these depressed persons is that so commonly when they go to a physician they complain only of pains and aches all over and particularly in the abdomen. That's why so many of them manage to get themselves operated on to no purpose. Some of you may wonder why I, who spent most of my life in gastroenterology am today more interested in neuroses and minor psychoses. I had to learn about these nervous troubles because perhaps a third of the patients referred to me turn out to have a psychic problem. If I did not know how to recognize and treat these people I would be a very poor physician.

It took me many years to learn that in the cases of many of these people their depression came first and the pain was secondary. Usually the patient, her family, and sometimes her family physician felt that if I would make the colon comfortable the depression would clear up. Now I know that often in these cases if with the help of shock treatments my friend the psychiatrist drives out the depression, all the pains go too. It's the depression that comes first.

DIARRHEA DUE TO PANICS OF FEAR

For years I have wondered why in eight out of ten cases of diarrhea I never could find a cause.

Now I know that in hundreds of these cases the patient has one or two large loose bowel movements when he gets a panic of fear that he is going insane like Uncle Bill or Aunt Lucy. I'm sure that many of us, if we had our mother in the state hospital would feel terribly frightened if occasionally we felt a bit dizzy or jittery or fuzzy in the head.

To illustrate this type of case, a wealthy man was referred to me by a physician in New Orleans who wrote, "This fellow has a diarrhea the cause of which we just can't find. We have examined his stools in every way, and have had cultures made by some of the best bacteriologists in the country, but we can't find any pathogenic organism. Also we cannot find any lesion in his bowel."

Noticing that the man looked depressed, I asked him if when he got his sudden brief spells of diarrhea he had been panicky. He and his wife both nodded their heads, and the wife said, "Yes, doctor, that is his trouble. One of his near relatives is insane, and every-so-often he gets it into his head that he too is going insane. Then he goes into a terrible panic and 'tizzy;' he says to me, 'Any minute now I'll be screaming, and they'll be coming for me with the straight jacket.' Then he rushes to the toilet and has one or two big bowel movements." The diagnosis was as simple as that.

Many of the patients I see who have had the abdomen explored rather uselessly five or six times, when questioned will admit that each time they got operated on they had started to vomit violently and to get abdominal pains, because they had suddenly decided that they were going insane like some of their relatives had done.

WHY WE PHYSICIANS FAIL TO THINK OF MILD PSYCHOSES

Why do we physicians fail to think of these things? Mainly, perhaps, because we never were trained to think of them. The other day I was reading a little book published by my friend Dr. Joe Pratt; it contained the notes that he had taken some 60 years ago when he was following

Osler on ward rounds in Baltimore. I went through that book with care, looking to see if the great Osler had ever, during Pratt's residency, demonstrated a case of functional or nervous disease, and I could not find that he had.

Speaking to Pratt about this, he told me of another great American professor of medicine under whom he had studied. He said, "I doubt if in all the years in which I worked for that great man I ever saw him demonstrate a case of functional disease. He was not at all interested in such diseases. He was interested only in the human wreckage that he found every day in a big city hospital." Is it any wonder then that we men who were trained under such teachers fail to think of psychosis when an insane person comes into the office?

THE PSYCHOTIC PERSON IS OFTEN VERY WELL BEHAVED

Some of you, perhaps, cling to the old idea that insane people are either violent or in a stupor. Actually, many of them, even during a depression, will chat most sensibly with you in your office. I'm sure if as I am talking to a psychotic woman a physician were to drop in and join in the conversation, he might never suspect for a moment that he was talking to a person who was on her way to the mental hospital to have some shock treatments. Similarly, I have on occasions sat for an hour greatly enjoying the brilliant conversation of a manic woman who was just one jump ahead of a straight jacket. When manic she was one of the most fascinating conversationalists that I have ever listened to. Why? Because her mind was racing so rapidly, with mental pictures that were so vivid.

THE GREAT NEED FOR PRESENTING IN COLLEGES NOT THE RAREST CASES BUT THE COMMONEST TYPES OF CASES

I am interested when occasionally I drop in on some friend of mine, a professor of medicine somewhere, and he will say, "Look, Walter, this morning all the faculty and the upper classmen

get together for a big clinic in the amphitheater; and you are going to give the clinic. Now let's see, what would you like to have? We have a case which we think is a pheochromocytoma; we have a girl who looks as if she had a Cushing's syndrome; we have a case that looks a bit like toxoplasmosis; and we have a case of hypernatremia. Which of those would you like to show?"

And then, greatly to the disappointment of my friend, I will say, "No, up to 1950 when I left the Mayo Clinic we had had only 18 cases of pheochromocytoma, and hence your students when they get out are never likely to see a case. No, please send a resident into the hospital there and get me a little scrawny neurotic woman who has had at least six useless abdominal operations. That is the sort of case your students are going to see often when they get out and that is why I would like to demonstrate an example; I doubt if you ever will!"

THE CHANCE REMARK THAT OFTEN MAKES THE DIAGNOSIS

In hundreds of cases in which for a while I have been puzzled, I have just kept on questioning the patient until all of a sudden some remark was made which showed me I was dealing with a mild psychosis. For instance, one day one of my associates said, "Walter, see what you can make of this young woman; I don't know what is the matter with her. I have put her through the diagnostic mill but nothing has come out. As you see, she is a beautiful girl of 25 who recently had a baby. She says she feels awful, but I cannot find anything wrong."

I sat down with that woman and kept talking to her. For a while I didn't get anywhere, then by chance I "struck pay dirt." It was a Saturday morning and I remarked that Rochester might be a bit dull for her all alone over the week-end; I asked her if she liked the movies and she said, "I used to be crazy about them, but now I never go." I asked why she did not. And she said, "Those people up there on the screen do not

interest me anymore. I haven't the remotest interest in what they are doing. I cannot seem to get into any contact with them. I sit there and my only thought is, supposing I were to get very ill—where would I find a doctor. That is the way I am: all wrapped up in myself all the time."

I then asked, "Have you lost interest also in your family?" And she said, "Yes, that distresses me. I have lost all interest even in my mother whom I used to adore. I am neglecting my handsome husband; I am not writing him, and I can't feel my old love for him." I said, "Why didn't you bring your infant child with you?" And then imagine my surprise when she said, "I left the baby with my mother because I am so scared I will kill it."

After chatting with her another half hour I was satisfied that the woman was mildly but definitely psychotic. When I told my friend that his patient was psychotic I think he thought something was going wrong in *my* head!

On another day, one of my consultant friends happened to want to go deer hunting so he asked me if I would see to dismissing a patient of his who had just been through the Clinic. She was a wealthy, beautifully-dressed and pleasant-appearing woman of 50. On picking up her record I found that she'd been to the Clinic four times, and each time gall stones had been found. Each time she had been seen by a surgeon: okeyed for operation, and given a card for St. Mary's Hospital. Then each time the record went blank; there was nothing there to say what had happened, but obviously the woman must have gone home.

Now the most distressing thing for a medical teacher is the complete lack of curiosity that young assistants often show. In this case, no one showed any curiosity as to why the woman had not been operated on. No one wanted to know why each time she had taken French leave, or why always after doing this she had returned for another opinion as to her gall stones. Fortunately I still retain much of the curiosity that I had as a child, and so I asked her if she had not seen

also many other surgeons in regard to her gallstones, and if these men had not advised an operation. She said, "Oh, surely, I saw Finney in Baltimore, I saw Erdman in New York, I saw Deaver in Philadelphia, years ago I saw Murphy and Ochsner in Chicago, I saw Rixford and Terry in San Francisco, and I saw Matas in New Orleans." I said, "But why did you not go ahead with the operation?" After looking about to see that no one could overhear, she said, "You see, each time as I was going out to the hospital I suddenly sensed that my family, in order to get my money, were going to pay the surgeon to cut an artery and let me bleed to death on the table!"

Another day I had a woman in who was a puzzle to me; she was complaining of aches and pains all over; gradually I began to sense the fact that she was mildly psychotic. But still it took some questioning before suddenly the cat came out of the bag. I asked her if she had any phobias. She said, "Yes, I can't go on the street alone because soon I don't know who I am or where I am, then I get sort of stuck to a spot on the sidewalk; I can't move from it; I become hysterical, and people run up and help me into a cab and send me home!"

With that as a starter, I went on and obtained much evidence to show that she was so psychotic she belonged in the hands of a psychiatrist. As I remember, her home doctor had sent her to me as a case of duodenal ulcer.

I often say to my internist friends, "I would be willing to bet money that if I could sit alongside of you in your office for the next few days, I could show you that a number of your patients are decidedly psychotic, and that is all that is the matter with them. Your diagnosis of a low blood sugar, or a low hemoglobin, or a low blood pressure is not important."

PATIENTS WHO RESENT A CHEERING DIAGNOSIS AND A GOOD PROGNOSIS

As you all know, sensible persons with only a neurosis, when told that they have nothing

wrong with them that a little rest would not cure, are happy and grateful. They accept the diagnosis and go home satisfied. The somewhat psychotic persons often seem to resent a cheering diagnosis, and some of them will get decidedly annoyed with the physician. Many a time I have had a person of this type get so angry, I have had to say, "Hold on a minute, it isn't my fault that you didn't come in with a cancer of the stomach."

A man of this type, who came in the other day, said that during a year and a half he had had nine X-ray studies made of his silent gallbladder. Eight times a roentgenologist had said, "I can't see anything wrong with it." Finally, to the patient's great joy, the ninth roentgenologist said, "Well, that gallbladder is a little big; its neck is a little kinked; and it empties a little slowly; I think we can say it is diseased." The patient rushed off to a hospital where he tried to get a surgeon to operate. Fortunately, the surgeon refused to have anything to do with him. Now this man is going the rounds of more roentgenologists trying to get a few more positive reports; enough so that he can induce a surgeon to operate on him!

Certainly this fellow is not behaving like a sane man, and yet he is a well-to-do person who has succeeded in building a big business. On asking about his relatives I found that some of them were mentally queer.

PEOPLE WHO ARE UNDISCIPLINED

One can often make the diagnosis of a mild psychosis as the patient goes through the office. The person is often difficult to handle, often unreasonable, often undisciplined, and often a chain smoker. Give a woman like that a dozen barbiturate tablets to help her sleep, and she may take six of them around ten o'clock and the other six before morning. Then next day she comes in to complain that all they did for her was to make her want to climb the walls like a crazed cat.

Another trait of the mildly psychotic person

is that she insists on doing all the talking. She won't listen long enough for one to finish a sentence. She doesn't seem to be interested in what the doctor tries to tell her. Obviously, one can never get anywhere with psychotherapy with such a person because she will not listen, and she is not interested. I always get rid of such a woman as quickly as I can because I hate wasting my time. I am reminded of what a trainer of monkeys for the vaudeville stage once told Charles Darwin. He said he could quickly pick the one monkey out of 25 who was trainable. How? He took the monkey who would listen when he was talked to! Monkeys who would not listen could not be taught.

DOCTORS TODAY DON'T RECOGNIZE PSYCHOSES EVEN WHEN THEY ARE PRESENT IN THE WIFE

Do you know why I'm so certain that few doctors today recognize psychoses. Because so often a physician brings me his depressed wife who really ought to be in a mental hospital getting shock treatments, and he does not seem to have had any idea of what is wrong with her.

For instance, one evening after my lecture a sweet old doctor asked me what would be good for his wife's flatulence. In a minute I found out that she had the flatulence in spells of about two weeks; then she would go for about two weeks when she was perfectly well, and did not have any flatulence. When I asked the doctor what she was like when she had no flatulence, he said she was a wonderful woman and a wonderful wife. When I asked what she was like when she had the gas he answered sadly, "I hate to say this about my wife, but she's then a sort of devil who raises Cain with me, and blames me for everything that ever went wrong in our family. She then accuses me of sleeping with my women patients. I have a terrible time until she comes out of the spell."

I said to the man, "Which one of your wife's relatives is in the state hospital?" And he said

(as I remember), "Her aunt." "Now," I said, "didn't it ever occur to you that your wife has a two-week manic depressive cycle?" "My god," said the doctor, "I've never thought of that, but I see now that that is what she has."

The other day a surgeon brought me his wife whose abdomen he thought should be explored because of constant pain. Actually all she had was a bad depression which was cleared up by a few shock treatments.

Another physician brought me his wife of 50 who was going to be operated on because of constant distress in her abdomen. After one look at her sad apathetic face, I drew out the story of a bad menopausal depression with strong suicidal trends.

I could go on telling of many such cases in which a physician didn't recognize psychosis in his wife.

Worse yet, I could tell of many cases in which a physician so completely failed to recognize a psychosis in *himself* that he had his abdomen operated on several times. One such physician in one of his early depressions had his appendix removed; in another depression he had his abdomen explored, and in another depression he had his silent stoneless gallbladder removed.

THE PATIENT WHO HAS MORE A PSYCHOSIS THAN A NEUROSIS

An important point I want to leave with you is that I am convinced that in many of these cases the patients are more nearly psychotic than they are neurotic. This is an important distinction to make because the persons who were born to be psychotic are often chronic invalids for all their days in spite of every effort at treatment. They can be helped to get out of a mild attack of psychosis, but often they slip back in again. That is one reason why today the psychiatrists hate to even mention heredity in these cases. They say they would feel too hopeless about treatment if they were to admit the obvious fact that the person was born queer.

EQUIVALENTS OF PSYCHOSIS

One of the most important ideas that I can leave with you tonight is that most of these mildly psychotic persons are suffering from mild equivalents of psychosis. What do I mean by that? You all know that an insane woman can easily have among her descendants some alcoholics, some feeble-minded persons, perhaps an epileptic, perhaps a vagrant, perhaps a recluse or a religious zealot, or a crackpot or two, or a child who stutters, or wets the bed until he is 12, or a deaf mute. The *major* equivalents of insanity are pretty well known; it is the *minor* equivalents that we now have to learn to recognize.

To show you what I mean by equivalents, a brother of an epileptic married an apparently normal woman, and in the next three generations there were five epileptics, nine feeble-minded persons, two insane persons, one deaf mute, one criminal and one suicide. In addition there probably were many persons who were just sickly and hypochondriac and good-for-nothing. Isn't that an awful record? And I could give you several hundred such records.

I often think of the bad heredity of the kings and queens of my father's country, Spain. Ferdinand and Isabella had a daughter Joanna, who was definitely insane. Joanna, the Mad, had as near relatives Luis the Weak, Luis the Foolish, Maria the Licentious, Phillip the Imbecile, Luisa the Stupid, Francis the Bigoted, Carlota the Violent, Ferdinand the Brutal, Baltasar the Degenerate, and Phillip the Lazy.

Obviously, none of these people were insane, but they certainly were anything but mentally normal. They had equivalents of the insanity that afflicted Joanna.

Occasionally when I'm talking to one of my friends among the psychiatrists, he will say to me that he can show me any number of insane persons who haven't another insane person in the immediate family. My answer is, "Yes, I too have records of such people; but the important point is that in the family one can usually find a number of persons who were 'tetched' a

bit, as they say in New England; they got just a little of the curse."

THE FREQUENCY WITH WHICH ONE SEES CARRIERS

The number of these carriers of insanity is legion, and there is good reason for this. Do you realize how common insanity is in this country today? Actually, it is the commonest disease there is. There are 750,000 insane persons in hospital beds. Now just think of the number who are being cared for in homes; then think of the number of odd relatives these people have. Think of the one draftee in eight who gets turned down for military service because of mental unfitness. It is from off the fringes of this huge reservoir of insane and psychotic people that we get so many of our queer patients with chronic nervous ailments.

I began puzzling over this problem of carriers of insanity back in 1912 when I became well acquainted with the members of a fine and distinguished family. First a woman brought me her child who was mentally retarded. Then I noticed that the mother was a bit eccentric and soon I learned that at times she was psychotic; then I saw one of her handsome brothers who was a dipsomaniac. Next I saw a sister who was homosexual; and next I found out about the father's brother who in his small community was the town drunk. This drunk's brother, who was a fine distinguished man, must have been a carrier of a curse that had come down from his ancestors. He did not show it, but he gave it to three of his nine children. Ever since I got interested in that family I have been studying hundreds of other families like them.

The other day I saw two fine wonderful persons—man and wife—whose child is an epileptic idiot. Why did this disaster come to them? I suspect because they are carriers of bad genes which reenforced each other. The man's uncle is epileptic and the wife's aunt is insane.

THE GREAT USEFULNESS OF THE IDEA OF EQUIVALENTS OF PSYCHOSIS

Today I couldn't practice medicine without this tremendously helpful idea of equivalents of psychosis. To illustrate, the other day as I was about to run for a train to go to a meeting, my secretary came in to say that out in the waiting room was a pleasant woman who said she just had to see me because she had come all the way from Georgia, and she could not afford to wait around until I got back home. Looking at my watch, I said, "Well, I can give her perhaps 20 minutes; bring her in."

Quickly I said to the woman, "What is your main trouble?" She, a woman about 35 said, "For the last 17 years I have 'up-chucked' my breakfast almost every morning." Now you who were in the Army know how commonly this symptom was found in highly neurotic or mildly psychotic soldiers. I have heard so much of this symptom from relatives of the psychotic that I quickly asked her, "Who in your family was a bit odd or queer or mentally upset?" She said, "I have a brother in the state hospital, and I had an uncle who drank himself to death, so I guess you are right. I have always suspected that this curse of mine is my small share out of the family's big curse. I have been through several clinics, and have had my stomach and esophagus X-rayed a dozen times, and so I have no desire to go through that again."

When I told the woman that I knew that her trouble was functional and that I was satisfied that it was an equivalent of the family tendency to psychosis she turned around and went home, satisfied.

One day when I was in New York and a friend, a leading consultant, said to me, "Do me a favor; see with me the wife of one of our leading bankers. She's a woman of 45 who has been on our necks for 25 years or so; she is always complaining and ailing. We have given her every known test, and we can't find anything wrong with her." Later in my friend's office, I

met a fine-looking stoutish woman; when I asked her what her main trouble was, she said, "I am so tired in the morning when I wake that it hurts terribly to think of getting up. It's not an ordinary fatigue, Doctor, it is a terrible, sickening, depressing fatigue. It fades during the day so that by four o'clock I'm pretty well, and by ten o'clock I feel wonderful and want to go places."

I am sure all of you old clinicians know immediately that that is the type of fatigue which is due to an inherited curse. So I said to my friend, "What'll you bet that I can make the diagnosis with one question?" Turning to the woman I said, "Who in your family suffered from melancholia?" And she said, "My mother went insane when I was born and she's been in and out of a mental hospital ever since!"

As I said to my friend, "I won't blame you if you think I've lost my mind; I won't be hurt if you take no stock in this diagnosis; and yet, don't you think it's more than a coincidence that I knew that this woman had melancholia in her family?" I don't know whether my friend believed me or not, but he was polite and acted as if he did.

WHAT ARE THE COMMONEST EQUIVALENTS OF PSYCHOSIS

Recently in an effort to find what are the commonest minor equivalents of psychosis, I asked my secretary to pull from my files some 600 records of persons in whose case I had got the story of psychotic or alcoholic relatives. In this particular study I did not include many of the relatives of the epileptic.

I then dictated the symptoms complained of by 574 of these people. Later I sorted these symptoms out into groups and tallied them. Following are the figures I obtained. At least 37 per cent of the "relatives of the psychotic" had suffered from depressions and blue or despondent spells. Curiously, 37 per cent of the 324 women complained of abdominal bloating, usually of the hysterical non-gassy type.

Some 35 per cent of the 574 complained of great nervousness. At least 31 per cent had suffered from some disorder of personality or poor adjustment to life. Thirty per cent were full of fears and phobias and anxieties; 25 per cent had had short spells of diarrhea; 23 per cent suffered from morning fatigue; 23 per cent at times had queer feelings and paresthesias; 23 per cent had trouble sleeping; 23 per cent had sick headaches; and 22 per cent of the women had been too odd or neurotic to marry.

Some 21 per cent of the 574 were "worry warts;" 21 per cent had non-migrainous headaches; 18 per cent complained of spells of giddiness and a loss of the sense of balance; 18 per cent had pains here and there; 17 per cent were champion air gulpers and belchers; 17 per cent regurgitated their food much as a baby "boils over;" 17 per cent were much too tense; 16 per cent ached all over or just here or there; 16 per cent suffered from "queer spells;" at least 15 per cent of the women suffered from hysterical manifestations; 15 per cent vomited easily; 15 per cent complained at times of nausea; at least 14 per cent suffered from epilepsy; 13 per cent were constitutionally inadequate; 12 per cent at times had an irritable bladder; 12 per cent were often jittery and shaky, 12 per cent were dazed or dopey or toxic; 12 per cent had vague abdominal distresses; 12 per cent passed an abnormal amount of flatus; 11 per cent had a weakness for being operated on to no great purpose; 11 per cent said they had had one or more nervous breakdowns; 11 per cent of the women were subject to nervous air hunger; 11 per cent of the 574 confessed to having a bad temper; 11 per cent of the women said they were sexually frigid; 10 per cent of the whole group were schizoids; at least 10 per cent of the women suffered from severe dysmenorrhea; 10 per cent could not hold a job or work; 10 per cent were overly irritable; and 10 per cent were hypersensitive; 8 per cent had burnings here and there; 8 per cent perspired heavily at times; 7

per cent were much distressed after defecation; 7 per cent were alcoholics; 7 per cent of the women suffered at times from anorexia nervosa; 6 per cent of the 574 had cold clammy hands; at least 5 per cent were hypochondriacs and 5 per cent were late bed wetters.

There were many other minor equivalents; so many that I cannot stop to describe them here.

IS THERE ANY USE MAKING THE DIAGNOSIS OF AN EQUIVALENT OF PSYCHOSIS

Some may ask, is there any use in making this diagnosis of an equivalent of psychosis. Yes, I am sure there is. In the first place, as in the cases of the woman whom I saw in New York and the one whom I saw as I was going to board a train, if one knows well the equivalents one can often make a diagnosis in a few minutes and be correct. Then one may be able to do a very fine thing and that is to save the patient from being operated on or being treated futilely for years.

Physicians ask me, "Do you tell a patient that his or her troubles are all due to a poor nervous inheritance?" "Yes, I do." "Doesn't that make the person sore at you and doesn't it discourage him or her terribly?" No, it doesn't do that. Actually I can assure you that hundreds of patients have walked out of my office very happy with an idea that made them almost well. This idea was that they had already got their share of the familial curse of psychosis. They knew what it was: it was their panics of fear or their spells

of jitteriness. This was their share, and it was probably all they were ever going to get of the family curse. Hence they no longer had to go on living in daily fear of becoming psychotic.

Many a time I have said to a fine successful business man of 55, "You, with your insane mother, do not have to go on fearing insanity as you've done all your life; we know by now that you are a fine sensible fellow who has always been a good business man, a good husband, a good father, and a good citizen. You are not likely now to change your whole nature; you can hardly go insane."

In this way I cheer up hundreds of people who for half a life-time have been living under the great shadow of the fear of insanity.

Naturally, there are some persons whom I feel should be gotten quickly into the hands of psychiatrists, and some of the depressed persons need shock treatments. Many of these people I think can be helped if they can only be taught to live with a better mental hygiene.

What I feel sure about is that all of us must learn more often to recognize persons with neuroses and minor psychoses. By so doing we can save ourselves endless time in futile treatment; we can save the patients endless time and money, and suffering, and we can save the almoners of a great city or university enormous sums of money now being wasted.

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SYMPOSIUM—SURGERY OF THE THORAX*

WILLIAM FRANCIS RIENHOFF, JR., M.D., *Moderator*

President Gundry, Dr. Acton, I think it would be well if the speakers on the Panel would now come up and I will introduce them ad seriatim.

* Presented before the Baltimore City Medical Society on Friday, October 8, 1954, in Osler Hall, Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland.

I want to say just two or three words because these gentlemen have limited time. There are seven speakers and unfortunately we have to limit the speaking time, as Dr. Acton has told you, to ten minutes because we want to have some time for questions and answers afterwards,

so in order not to run the meeting too late we will have to stick to our ten minutes.

You will note on this program I have rearranged the sequence. I thought anatomically it would be better to start with the chest wall and work in. And so we are having Chest Wall Surgery, with Dr. Otto Brantigan first, and Surgery of the Diaphragm, with Dr. William Garlick; Surgical Treatment of Tuberculosis, with Dr. Richard Kieffer; and Surgical Treatment of Bronchiectasis, by Dr. Hopkins; Mediastinal and Cardiovascular Surgery by Dr. Henry Bahnson and Dr. Cowley, and finally the Surgical Treatment of Ligation of the Oesophagus by Dr. John C. Miller.

There is just one thing I want to say before we begin and that is, I don't believe all of us are keenly aware of the fact that within the chest with the air-inflated lungs, there is a unique opportunity for the discovery of silent lesions due to the contrast between the air-containing lung and the densities produced by pathological lesions of various conditions. I think there is not any internal organ in the body in which we have a great opportunity to discover early lesions—malignant or otherwise.

As you know, thirty years ago we were all mainly and primarily interested in chest surgery only in cases of tuberculosis. I remember at the early meetings of the American Thoracic Surgeons, it was almost always tuberculosis that was discussed. Later we became very much interested in malignant tumors of the lung, and I am very

sorry to have to say that in spite of the fact that we have perfected the surgical technique to the extent that we can now deal with malignancy of the lung we are not receiving these cases early enough, that only about one-third are operable when explored.

Dr. Overholt published some statistics not long ago in which of silent lesions he operated upon, practically 90 per cent of them were resectable, and 75 per cent, I believe, showed no spread of the tumor beyond the lung.

I would like to suggest that we must be more bold not only medically but also surgically in insisting on exploratory thoracotomy when we are in doubt as to the true nature of the pulmonary lesion.

When I started out doing lung surgery here in 1932, a great many men thought it was just another form of euthanasia. But now, with our good anesthesia, our blood banks and antibiotics, I consider exploratory thoracotomy a very safe procedure and in many respects probably less hazardous from the standpoint of postoperative morbidity, than exploratory laparotomy.

Now then, I am going to call on Dr. Brantigan and as much as I hate to do this, I have to say to you, Otto, ten minutes, and the old saying is: "No souls are saved after twenty," you've got to save this one in ten. So if you will come up here, I will warn you in nine minutes with a little red light and then we have a terrific buzzer on the tenth.

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SURGERY OF THE CHEST WALL

OTTO C. BRANTIGAN, M.D.

Surgery of the chest wall is a rather extensive subject. However, the field can be organized in such a way that it can be covered in a reasonably short presentation. The surgical conditions

arising in the chest wall are: a) trauma; b) neoplasms, primary in type, benign and malignant, and secondary in type which are all malignant; c) infectious conditions of the chest wall; and

finally d) congenital chest wall deformities including deficiencies of the sternum with partial or complete absence of the sternum and in the extreme degree resulting in ectopic cordis, and the more common conditions such as pigeon breast and funnel chest.

In dealing with trauma of the chest wall, of course, ordinary lacerations and injuries are obvious and can be taken care of in the routine manner. Where there is a stab wound of the chest, there may be laceration of the chest wall as well as pneumothorax or hemopneumothorax, which are not covered by this discussion. One of the most common injuries to the chest wall is fracture of the rib. In most instances this can be treated in a more or less symptomatic manner. If the patient has a great deal of pain or distress the chest can be strapped. If he does not there is no need for strapping. On rare occasions the intercostal nerves may be injected with a local anesthetic which will sometimes give relief. On very rare occasions enough ribs are fractured so that the chest is flail, and therefore, some endeavor should be made to give external support to the chest. On rare instances there is a fracture of the sternum, and in some cases this can be flail-like and will need external support. However, in fracture of the sternum there is always the possibility of reflex laryngospasm, and there may be traumatic cardiac difficulties which may result in pericarditis or injury to the heart muscle.

In minor injuries to the chest wall treatment may be given without hospitalization. It is strongly recommended when the injury to the chest wall is severe that the patient be treated with caution, that the oxygen tent be used freely, and that the patient be given relief of his pain by narcotics.

A plea is made for the routine x-ray of all chests where trauma has occurred. Chest x-ray will show the presence or absence of trauma, and may show evidence of unsuspected pulmonary pathology. It is not uncommon to have a patient cough blood after trauma of either a severe or

minor degree, and routine x-ray of the chest shows no evidence of trauma, but shows some underlying pulmonary pathology, even bronchogenic carcinoma. The symptoms of trauma to the chest and of carcinoma of the lung may be exactly similar; chest pain, cough, and expectoration of blood. Therefore, the plea is being made for the routine x-ray of all chests where the patient has received trauma to the chest.

So far as neoplasms of the chest wall are concerned, there may be the ordinary benign tumors that involve skin, subcutaneous tissue, muscle, and so forth, that cover the chest wall, and the important, but reasonably rare group of tumors that involve the pleura. These pleural tumors may be benign or malignant. Very often sarcoma involves the intercostal muscles. When there is suspicion of a primary tumor of the chest wall, it must be approached as though it is malignant. When such a tumor is removed it should be approached surgically in such a way that a wide excision of the chest wall can be done in order that a cure might be obtained. If a sarcoma of the chest wall is adequately excised in an early stage, it is reasonable to believe that the patient will not have a recurrence of the disease. Secondary tumors of the chest wall are extremely important from the standpoint of the diagnosis of a primary malignancy elsewhere. When an involvement of the bone is noted, there is no way of knowing for certain whether it is a primary bone tumor or a metastatic bone tumor. In either event, it should be removed for pathologic study. Of course, there are the benign giant cell tumors of bone, cartilage, and so forth that occur in the ribs. These will not be confused with metastatic involvement of the ribs. Therefore, from the standpoint of secondary tumors, it is important to biopsy the tumor because it will often lead to the correct diagnosis of the primary malignant disease.

Infections of the chest wall are less common now with good antibiotic therapy for pyogenic bacteria and with good antituberculous therapy for patients with tuberculosis. On rare occasions

chest wall infections may result from various types of pathogenic fungi. When treating infections of the chest wall, as with infections elsewhere, the type of organism should be determined in order that the proper antibiotic therapy can be administered. When it is necessary, such patients should have adequate excision or incision and drainage. Sinus tracts of the chest wall may be from bone, and when this is true they are most likely the result of tuberculosis. Such sinus tracts usually ramify over a very much greater area than is anticipated. Sometimes such sinus tracts communicate with the pleural cavity and are evidence of an old chronic empyema or abscess. On occasion they may communicate with bronchiectatic cavities or parenchymal lung disease. The cold abscess (tuberculous abscess) of the chest wall is often confused with a lipoma of the chest wall.

In dealing with congenital deformities on the chest, the one involving an absence of the sternum is probably the rarest of the group. Complete separation of the sternum is extremely rare. Often this is associated with an ectopic heart. In all instances of this unusual condition an endeavor should be made to restore the heart and the chest by immediate surgery. Where there is a partial splitting of the sternum or absence of the sternum, careful judgment must be exercised as to when the patient should be operated upon or whether or not the patient should be operated upon in an endeavor to overcome the deformity.

Those individuals who present a pigeon breast often can have a great deal done for them in order to make the deformity less prominent.

Funnel chest is a relatively uncommon condition, but it occurs frequently enough that it is well to urge early correction of this deformity. Probably the condition is caused by a short diaphragm exerting undue pull on the xyphoid process and the adjacent anterior costal margin. It has been definitely proven that it is not associated with dietary or vitamin deficiency, nor is it associated with other systemic diseases.

If the profession is alerted to its possibility, the condition can usually be diagnosed within the first few months after birth, and when it is diagnosed before the age of twenty months, a simple operative procedure can be used in its correction. The simple operative procedure is merely excision of the xyphoid process with detachment of the diaphragm from the costal margin adjacent to the sternum and xyphoid process. Such an operation requires the patient to be in the hospital only a matter of several days. A much more extensive operative procedure is necessary after the patient becomes twenty months of age or older. The corrective operation for the older child or adult includes excision of the costocartilages and an osteotomy of the sternum in order to bring the chest up to its normal position. It is a rather extensive operative procedure, but a relatively safe one. The corrective operation for the deformity of funnel chest can be done at any age, but the best time is between four and six years of age.

Repair of the funnel chest is necessary in order to eliminate the psychological factor that always accompanies such a deformity and to protect the cardiac function in the years to come. The profession is urged to be on the alert for funnel chest so that it can be diagnosed and treated in early infancy when the operation is a relatively simple one.

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DR. RIENHOFF: Thank you, Dr. Brantigan. I might add that in looking up the data on the chest surveys, it was very interesting to me that in addition to incipient tuberculosis, silent tuberculous lesions, or very early tuberculous lesions, 0.2 to 5 per cent of non-tuberculous lesions were discovered including deformities of the chest wall, cardiac abnormalities, abnormalities in the cardiovascular shadow and other disturbances in the chest and affections of the thoracic contents which had not been suspected.

The next paper will be Surgery of the Diaphragm, by Dr. Garlick, whom you all know. An Associate of Dr. Wise, at Mercy Hospital.

SURGERY OF THE DIAPHRAGM: PITFALLS OR PECULIARITIES

WILLIAM L. GARLICK, M.D.

Dr. Rienhoff, Gentlemen, the title of Surgery of the Diaphragm reminds me of that story that Julian Johnson told at the Semiannual meeting. He said he was exactly like the Persian who inherited a harem. He knew what to do but he didn't know where to begin. That is just the way I feel tonight, so I'll just begin and I hope I can discuss surgery of the diaphragm.

The diaphragm is a septum between cavities of different pressure beyond its primary function as a muscle of respiration. It is also used to increase abdominal tension and offers a retention wall to extension of fluid or pus collecting in either serious cavity which it divides. Its contraction is responsible for quiet inspiration. It is surgically continuous with the transverse abdominal muscle which has been used in the congenital absence of the diaphragm to create a partition which is necessary for both respiration and gastrointestinal function. It aids in the diagnosis of a perforated viscus by molding into a typical shadow, air collected in either of its surfaces, i.e., that of pneumothorax or that of a perforated peptic ulcer. Air beneath the diaphragm may be confused with a high gas filled colon, particularly on the right side. It may eventrate, ballooning upward into the thoracic cage and produce few if any symptoms or with increasing age in the patient, respiratory embarrassment. Eventration is an abnormality which rarely requires surgical interference, but if performed, consists of imbricating the tendinous dome of the diaphragm to shorten its diameter without interference to the phrenic nerve and blood supply or embarrassment of its orifices. Sections of the muscle may hypertrophy, particularly the muscle sling about the esophageal orifice, producing obstruction by a sphincter-like action.

Absence of the diaphragm in part or whole is

a surgical emergency on diagnosis in the newborn. The child usually exhibits cyanosis, a misplaced apical heart beat and borborygmus may be heard under the clavicle. These hernias, of the foramen of Bochdalek, are usually false and without a sac and often contain all the abdominal viscera except the liver and descending colon. Various surgical approaches have been used. The thoracic incision lengthens the time of surgery and requires more handling of abdominal viscera in placing bowel, stomach, colon and spleen into a space which is often too small. The more rapid and easily accessible approach is a high left rectus incision. Air injected into the thorax will empty out the abdominal contents without trauma from pulling or pushing. By closing only the skin and subcutaneous tissue a larger and adequate abdominal cavity is created. After a period of about eight days or more the incisional hernia may be closed with the infant's recovery. Hernias of Bochdalek carry a rather high mortality because of lung agenesis or other abnormalities.

Another foramen, that of Morgagni, allows the protrusion of viscera into the anterior chest or allows inflammatory processes to enter the abdomen, the most common being a cold abscess from mediastinal tuberculous gland necrosis. Abscesses such as those following peritonitis or surgery when subdiaphragmatic in character, may be drained through the attachment of this muscle through the bed of the twelfth rib. Neither pleura nor peritoneum need be contaminated. Early recognition avoids mortality.

Traumatic rupture of the diaphragm is a surgical emergency after proper control of shock and hemorrhage. In such an event, frequently other organs are ruptured such as the liver or spleen. Immediate surgery is frequently required at the earliest feasible moment in order to restore

proper respiratory function and overcome anoxia. The rupture is more easily corrected through a thoracotomy incision than an abdominal approach. Bullet wounds of the diaphragm per se do not require surgical interference although the spleen may escape under duress of stress at the moment of perforation into the chest. The small opening compresses the venous return allowing a huge enlargement of the spleen. This may trap an enormous blood volume creating an overloaded cardiovascular system with cardiac failure at the moment of its surgical release. A fatality may be avoided by allowing a slow release of blood through normal control of the splenic pedicle.

The most common surgical lesion of the diaphragm is the esophageal hiatal hernia which is a true acquired hernia. The symptoms may be controlled by medical means except when incarceration occurs with obstruction, or hemorrhage from ulcer and erosion of stomach or bowel, or when volvulus occurs. Two other variations of this hernia are seen: the sliding type and the paraesophageal type. Each must be recognized for its proper surgical correction. The thoracic

approach is preferable when incarceration, strangulation or ulceration is present. The choice of approach is otherwise a matter of individual preference. The esophageal opening must be sutured surgically to permit the transmission of esophagus containing a Levin tube and the end of a finger. The opening is best brought forward toward the center of the diaphragm in order to effect a more adequate suture closure in the slip of diaphragm which allowed the herniation to protrude into the thorax. Paralyzing the diaphragm by phrenic crush is not a method of cure although it may relieve symptoms.

There is very little mortality in surgery of the diaphragm. The problems encountered are primarily diagnostic. There are no particular pitfalls or peculiarities of the pre and postoperative period specific to surgery of the diaphragm.

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DR. RIENHOFF: Thank you, Dr. Garlick, that was a very splendid presentation.

The next speaker will be Dr. Richard Kieffer, whose title is Pulmonary Resection for Tuberculosis.

PULMONARY RESECTION FOR TUBERCULOSIS

RICHARD F. KIEFFER, JR., M.D.

Dr. Rienhoff, Ladies and Gentlemen, I would like to confine my comments to a brief consideration of some of the indications for pulmonary resection in the treatment of the tuberculous patient. For the sake of convenience I have arbitrarily divided these indications into five categories.

One of the cardinal reasons for advising excisional surgery is for the establishment of a diagnosis. This is particularly true in the case of an asymptomatic, middle-aged patient with a solid parenchymal lesion discovered on a routine chest roentgenogram. When the sputum is nega-

tive for acid fast bacilli and pathogenic fungi and when bronchoscopy and examination of the bronchial washings do not serve to establish the diagnosis, thoracotomy is usually necessary because of the possibility of malignancy. But even cavitory lesions which persistently fail to produce tubercle bacilli should be viewed with suspicion for it is not at all uncommon for excavation to develop in a malignant neoplasm.

A second indication for resection is to bring about the arrest of active disease, that is, usually cavitory disease. In this instance, success is determined by the judgment exercised in selecting

the proper timing for operation. Such a decision must take into account the extent and distribution of the disease, the degree to which pulmonary function has been impaired by the disease and might be further reduced by the surgery contemplated, the efficacy of the chemotherapeutic agents available (in other words whether the patient's organisms have become resistant to the more efficient agents), and of course, the general condition of the patient. In most patients these factors will all be present to a greater or lesser degree thus making each decision an individual one. But to state the case as simply as possible, it is now customary in many hospitals to consider seriously the resection of cavitory disease which persists after the completion of six months of chemotherapy. The selection of this time is not purely arbitrary because extensive study has shown that organisms still present in active cavitory disease after such a period of chemotherapy will in many instances begin to develop resistance to the antibiotics with the probability that pulmonary resection will have to be carried out at a later date without the patient having effective protection from his medication. In this group also belong the thoracoplasty failures. These cases, a few years back forming the prime indication for resection, now constitute a small percentage of the patients coming to thoracotomy.

Considerably more controversial is the need for resection of damaged or destroyed lung in a patient whose disease has been rendered bacteriologically inactive by prolonged chemotherapy. Such a lesion would be the residual annular shadow which in some cases may represent a cavity which has undergone open healing with epithelialization of the wall or in other instances may be a fibrous walled cyst which characteristically develops and enlarges as the tuberculous process resolves. With the means now available it is very difficult to be sure exactly what such an annular shadow represents. But it is known that the relapse rate in such patients is high making resection of this portion of the lung de-

sirable. Also in this group should be included the patients whose bronchial tree as demonstrated on bronchography shows so-called post-tuberculous bronchiectasis. In using this term we must keep in mind the fact that some pathologists, notably Rich and Medlar, have advanced convincing arguments based on careful examination of resected tissue to the effect that in at least some cases these bronchial distortions appear to be on a congenital rather than an acquired basis. However, such a differentiation must be made histologically rather than clinically and the term bronchiectasis continues to be used in this broad sense to describe the radiologically demonstrable abnormality. Because such damaged lung may represent an area of low resistance to tuberculous infection with a predisposition to relapse, and because it may be subject to non-tuberculous complications such as pyogenic infection and hemoptysis, some surgeons consider this an indication for resection. At the present time we do not feel that the isolated finding of bronchiectasis in a patient who has otherwise handled his infection well requires excisional surgery. But if it is present in conjunction with other factors, it may weigh the balance in favor of the surgical approach.

Perhaps the greatest disagreement centers upon the indication for resection of the closed residual lesion. By this I refer to the radiologically demonstrable residue, which persists after maximum resolution of the reversible component of the disease has taken place, after the cavities have closed, and after the sputum has become persistently negative. In the case of a patient who has responded well to a prolonged course of antituberculous chemotherapy, histological study of such lesions shows most of them to be composed of necrotic caseous material in which acid fast bacilli can be frequently seen but usually not demonstrated to be viable by the customary bacteriologic methods. Until the past year or two such foci have been considered to possess all the ingredients necessary for the relapse of the disease. There is now considerable

doubt as to the validity of this concept and many people feel that prolonged chemotherapy as it is now applied will render such lesions relatively innocuous. The answer to this question will be available only after completion of a careful follow-up study comparing the relapse rates in those patients who have undergone resection with those who have received only medical treatment. At the present time we are inclined to advise resection of the larger residual lesions if they are well localized, particularly if the patient is young. We are also inclined to advise excision if the patient gives evidence of poor resistance to the infection, such as a previous relapse or slow response to his medical treatment.

The last category covers the so-called salvage cases, that is, patients who are poor candidates for any operative procedure but in whom resectional surgery seems to offer the only hope of avoiding a fatal outcome. Examples of these cases would be bronchopleural fistula with mixed empyema, uncontrollable pulmonary hemorrhage, and fulminating unilateral disease which will not respond to antibiotic therapy. Fortunately we do not see such cases very often. Though the mortality rate is high, a bold operation performed even under these adverse circumstances may at times be life-saving.

As I have tried to bring out, there is considerable disagreement concerning most of these indications for pulmonary resection. The disagreement, of course, stems from the fact that

statistical data based on follow-up studies on many patients are not presently available. Because of the chronicity of the disease, it will be a long time before dogmatic statements are justifiable and before we know when or if pulmonary resection should be used to supplement the medical regimen in the treatment of any particular patient.

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DR. RIENHOFF: I want to be sure and not take up too much time because I know that you will want to ask the speakers questions which they will be delighted to answer. But I do want to say one thing apropos of Dr. Kieffer's discussion. I really think the coin lesions which we call tuberculomas should be removed surgically, although they may have tubercle bacilli in smears that may be dead or alive. In our experience about half of these round coin lesions are full of tuberculous caseous material which I consider a rather dangerous lesion, because they may ulcerate into a neighboring bronchus, while the other group are more or less solid and have an onion-like appearance when you incise them. These coin lesions are often very difficult to differentiate by x-ray from early bronchiogenic carcinoma.

In fact we have, Dr. Kieffer, Dr. Brantigan and I, had two instances some years ago in which it was almost impossible to differentiate them from tuberculomata, and they turned out to be early bronchiogenic carcinoma.

I think we should regard all those lesions as possible malignancy until proved otherwise.

Now, the next paper will be by Dr. James Hopkins, on the Surgery of Bronchiectasis.

SURGERY FOR BRONCHIECTASIS

JAMES E. T. HOPKINS, M.D.

I am fortunate in the choice of my topic because most of you have seen and perhaps see daily, cases of bronchiectasis. It is a common condition. Various people have estimated that two to five per cent of individuals who are autopsied show evidence of bronchiectasis.

The important thing about this condition is that we can now do something about it. A high percentage of bronchiectasis patients can now be treated surgically. My purpose here tonight is to encourage you to seek surgical aid, for diagnosis and treatment of this condition.

As far as the surgery goes, the results were not always as successful as they are now. From 1914 to 1935, approximately 196 operations were reported for bronchiectasis with a mortality of 34%. This mortality gives us the answer, as to why, physicians and patients have until recently been discouraged with the treatment of this condition. The fact that these operations were done in the face of such high mortality, emphasizes what a terrible and dreadful condition bronchiectasis can be.

It is true that within the past few years, with the development of antibiotic therapy, the outlook of a bronchiectasis patient is perhaps better than it was back in those days, but I think everyone recognizes even now that one certainly cannot cure the condition by antibiotic therapy. Wise and careful use of antibiotic therapy will be especially useful for those that are not suitable for surgery. They can be kept fairly comfortable and their lives can be prolonged.

The good results began around 1933, when Doctor William Rienhoff removed the first lung by the individual ligation technique. This created a surge of effort as far as working out new techniques were concerned. From 1933 on, numerous reports began to appear about the successful excision of lungs, lobes and segments for the treatment of bronchiectasis.

One very dramatic report was published in 1944. Meade, Kay and Hughes, who had been doing work for the Army, reported 244 resections for bronchiectasis with one death. This, to me, was a very dramatic accomplishment.

In Medical School, I looked upon thoracic surgery as a sub-specialty which had not developed very far. There were only a few people in the country doing it, and I must say, as far as bronchiectasis was concerned, I thought of the condition as being a hopeless situation. I visualized destruction of many bronchi with resultant cough, foul sputum and invalidism. My ideas have since changed and I now realize that bronchiectasis is a condition that can be fairly silent at times, but, at other times gives quite a bit of trouble in the way of chest signs and symp-

oms. You as practising physicians are familiar with the signs that are helpful in diagnosis. Asthmatic bronchitis is at times a clue. Recurrent deep chest colds should lead us to suspect the condition.

I must say that I am continually surprised in doing bronchograms when bronchiectasis is found where there was perhaps just a slight chance of it, especially in young individuals. The more of this I see, the more I realize that the signs, symptoms and resultant disability are progressive in many of these people.

The important thing about picking up bronchiectasis, I think, is to remember that any individual who has a suppurative condition of the lung that has not responded fairly quickly to medical therapy, deserves work up in order to tell why he has that cough or that sputum or that hemoptysis, and try to find out where it is coming from.

In your efforts to diagnosis bronchiectasis, you will, of course, pick up tuberculosis, carcinoma, lung abscesses and lung cysts, and many obscure conditions which can be treated by thoracic surgery.

The simple X-ray helps us considerably in the diagnosis of bronchiectasis. One can get a lead from perhaps a shift of the heart to the left or an elevation of the diaphragm, or ring-like shadows in the lung. Many of these individuals show increased bronchial markings over the base. The actual diagnosis of bronchiectasis in most cases is relatively simple. It consists in doing a bronchogram. A bronchogram is a very simple procedure. It can be done either separately from a bronchoscopy or shortly after one has actually removed the bronchoscope. A catheter is placed in the trachea. The patient is taken to the X-ray Department. Contrast material is injected and the proper films taken. Iodochloral and lipiodol are commonly used with very good results. Recently aqueous dionosil has proved very useful. Bronchograms with this material show uniform mucosal coating and demonstrate the small peripheral bronchi. Alveolar filling is slight. The substance rapidly disappears from the lung.



FIGURE 1



FIGURE 2



FIGURE 3A

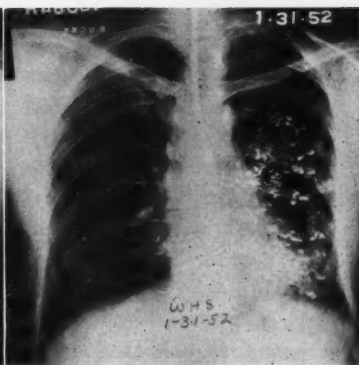


FIGURE 3B

Figure 1. This film shows bronchiectasis in the left lower lobe. Recurrent chest colds for 7 years had been the chief complaint of this 33 year old man. The onset was related to atypical pneumonia. The basal segments of the left lower lobe were removed and all symptoms eliminated.

Figure 2. Cystic bronchiectasis is demonstrated in the right upper and middle lobes. A slight cough productive of a small amount of sputum occasionally blood streaked had been present for 7 years. Removal of the two lobes eliminated the symptoms.

Figure 3A and 3B. Figure 3A demonstrates a normal bronchial tree, on the right. Figure 3B shows a left lung completely involved by cystic bronchiectasis. For 10 years before admission, this 33 year old man had many attacks of respiratory disease with cough, sputum and

fever. Removal of the left lung eliminated the symptoms.

Figure 4. Here a spot bronchogram shows bronchiectasis in the apical and posterior bronchi of the right upper lobe. Eight months before admission, the patient developed a cough productive of a small amount of yellow sputum.

Ten months after the onset of his disease, he had a segmental resection. Recovery was rapid.

Figure 5. Bronchiectasis is demonstrated in the right upper lobe under a thoracoplasty. It of course was present before the thoracoplasty which was done for tuberculosis. Chronic cough, sputum and hemoptysis were eliminated by resection.

Figure 6. This bilateral bronchogram shows bronchiectasis in all segments of both lungs. Surgery could not be done in this case.

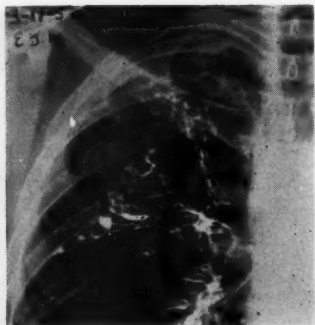


FIGURE 4

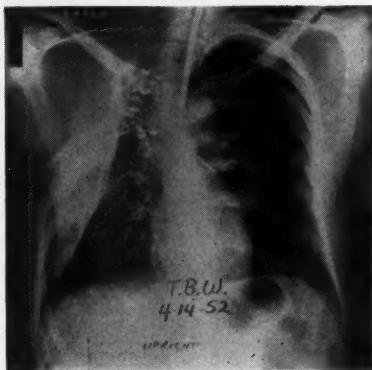


FIGURE 5

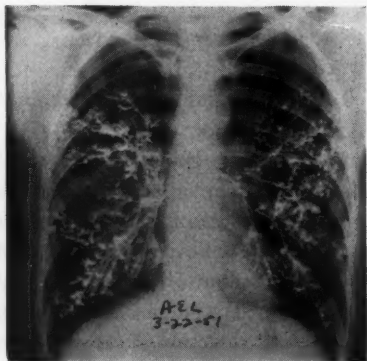


FIGURE 6

The decision for surgical treatment of bronchiectasis can only be made after complete diagnosis and evaluation of the patient's condition. All segments of both lungs should be outlined. The age, physical status, degree of bronchiectasis, chest signs and symptoms, all help in the

plan of possible surgical attack. Few patients below the age of 50 need be turned down for surgery.

The chest surgeon should never lose sight of the fact that surgery for bronchiectasis is elective. Every advantage should be taken of antibiotic therapy and other measures to clear up sputum and improve the patient's general condition. Bronchospasm should be cleared if possible before surgery.

The anatomy of the lungs is now so well known that no excuse exists for needless sacrifice of good lung tissue. Segmental resection thus plays a large part in the treatment of bronchiectasis. The disease is basically a segmental condition.

The commonest resection consists of the removal of the basal segments of the left lower lobe and the lingula segment of the left upper lobe. On the right side the anterior segment of the right upper lobe is often removed with the middle lobe. Another common procedure consists of removing the lingula and basal segments on the left, and at a later stage, the basal segments on the right. Cases are often seen when only the middle lobe on the right or the lingula on the left is involved.

The mortality and morbidity associated with bronchiectasis surgery is now very low. A mortality of 1% should not be exceeded in people below 50. Serious postoperative complications are seldom seen. Bronchopleural fistulas and empyema are very rare. In many cases after a few months the chest is quite clear. The majority of operated patients leave the hospital within two weeks after surgery. Many can be at work 6 weeks after surgery.

In summary, bronchiectasis can give minimal or maximal signs and symptoms. The severity of the condition seems however to progress with age. The diagnosis is simple and not hard on the patient. One or two days in the hospital for bronchoscopy and bronchograms are usually all that are required to confirm the clinical impression. Surgery, in most cases, is definitive and successful. Mortality and morbidity are low.

Treatment need not be delayed in this condition which affects not only the physical but also the emotional well being of the unfortunate patient.

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DR. RIENHOFF: Thank you very much. The hour is getting on. I won't elaborate on this excellent presentation.

We all know the dramatic heart surgery that Dr. Blalock performed, but I want to say just one word about Dr. Bahnson, who is going to talk about the surgery of the mediastinal structures. I don't think many of you have had the opportunity I have had to watch him remove aneurysms. First they put in homo grafts. Now nylon grafts are used which look like a small pair of pajamas. Placing of a nylon graft in the end of an aorta and into the common iliacs is really a very dramatic procedure.

SURGERY OF THE MEDIASTINUM

HENRY T. BAHNSON, M.D.

The mediastinum is defined as that part of the thorax between the two lungs and is the most important region in the thorax since it contains all the important thoracic structures or, in the case of the lungs, their roots. I am not trying to say that my ten minutes is the most important dish in this seven course meal with Dr. Rienhoff sandwiched in between each course. The mediastinum was much more important before such great strides were made in pulmonary and cardiovascular surgery. I will limit my remarks to a few general comments in regard to mediastinal tumors.

Mediastinitis may occur from rupture of lymph nodes but it is probably most frequently seen following perforation of the esophagus. It is occasionally seen after trauma, as an auto accident, more frequently from perforations from a sharp foreign body, as a chicken bone, or a perforation above an obstruction due to carcinoma or a stricture. Unfortunately, mediastinitis is also occasionally seen after a perforation as a result of surgical instrumentation as esophagocopy.

The diagnosis of mediastinitis is usually based upon a pain in the chest, dysphagia, and perhaps dyspnea; sometimes barium swallow might be needed. These are associated with signs of infection and a widening of the mediastinum by X-ray. Formerly the accepted treatment in al-

most all instances was drainage to the mediastinum as an emergency. This was important because there are no fascial planes to restrict the spread of infection in the mediastinum. Antibiotics have changed this but emergency drainage is still the best form of treatment with large non-malignant perforations. When carcinoma is present the patient must be carefully evaluated and occasionally an immediate resection and an anastomosis is the best form of treatment. In other instances drainage must be instituted. Some small perforations of the esophagus causing mediastinitis may be handled by antibiotics alone although still in many instances it is probably a safer practice to drain them.

Mediastinal abscess is at present a rare condition. It simply represents localized mediastinitis and doesn't often occur. Pyogenic abscess requires drainage. The most common abscess is probably due to tuberculosis from Pott's disease of the spine, and is an orthopedic not a thoracic surgical problem.

Mediastinal tumors have become of greater importance in recent years because of the possibility of removal of many of them. No symptom is either invariably or even commonly present but usually the effect of mediastinal tumor is pressure on one or more mediastinal structures. Pain is the most frequent symptom, but even that is present in only slightly over a third of the

benign tumors and in only half of the malignant ones. Pressure on the tracheo-bronchial system may cause cough, dyspnea or hemoptysis and pressure on the esophagus may cause dysphagia. Hoarseness is uncommon. The more commonly seen physical signs are usually due to obstruction of the great veins, particularly the superior vena cava, obstruction of which is frequently present with large mediastinal tumors. This causes edema, cyanosis of the face and neck, distended veins over the upper part of the body. In some instances a widened mediastinum may be perceived by percussion.

The diagnosis, however, is usually not based upon physical examination or from symptoms but upon radiological findings. It is only rarely that a specific diagnosis can be made prior to visualization of the tumor. The only pathognomonic sign is trichoptysis or a cough productive of hair as the contents of a dermoid tumor. One can guess, however, the type of tumor if he localizes the tumor radiologically and remembers the information on this slide. Neurogenic tumors occur most commonly in the posterior portion of the chest near the nerve roots and include tumors such as ganglioneuroma or sarcoma, neurinoma, neurofibromas, neuroblastomas. Substernal thyroids occur in the superior mediastinum along with an occasional parathyroid. Thymomas of course occur in this region. Teratomas are most frequently seen in the anterior midline and the lymphomas are usually seen in the region of the peribronchial lymph nodes. Pericardial cysts are most frequently seen in the cardiophrenic angles on either side or occasionally at the top of the pericardium near the origin of the aorta and pulmonary artery. Bronchogenic and enterogenous cysts occur characteristically near the tracheo-bronchial tree or the esophagus. An important differential diagnosis in the case

of mediastinal tumors is that of aneurysm of the aorta which can now be successfully treated in many instances and about which Dr. Cowley will probably speak.

If we could make a specific diagnosis, some of the operations upon mediastinal tumors could be avoided. This is true because almost all malignant tumors must be considered incurable although some of them can be controlled by surgery or irradiation. On the other hand a pericardial cyst is a completely benign thing and though easily removed does not harm the patient if left alone. Unfortunately, however, the localization is not absolute and many of them are dislocated, so that we can not determine the exact nature of these. In some instances irradiation may be given as a diagnostic and therapeutic trial. If the tumor shrinks it is likely a lymphoid one. In most instances operation and removal is indicated because of symptoms due to pressure of the tumor or more important the highly premalignant nature of many of the mediastinal tumors. This is true of the dermoids, the teratomas, neurogenic tumors and those arising from the thyroid. The size of the tumor should be no criterion as to the operability for some of the largest tumors can be relatively easily removed; this is particularly true of dermoid cysts.

One important tumor of the thorax has been left out of the discussion tonight, namely carcinoma of the lung. Dr. Rienhoff can speak with much more authority concerning this.

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DR. RIENHOFF: Thank you, Dr. Bahnson. I am sorry you didn't show one of those grafts of the aneurysms of the aorta. I know Dr. Evarts Graham would be delighted to see that slide of the mice.

Now, Dr. Cowley is going to speak to us on Cardiovascular Surgery. Dr. Cowley, as you know, is from University Hospital.

CARDIOVASCULAR SURGERY

R ADAMS COWLEY, M.D.

Today, heart disease is the leading cause of death in the United States. Compared with other diseases, heart disease takes a greater toll than the next five leading causes of death combined. In 1950, mortality statistics recorded that 745,000 people died from cardiovascular diseases. In second place, but far behind, stands cancer with 209,000 deaths; accidents 88,000 deaths; pneumonia 47,000 deaths; tuberculosis 34,000 deaths and in 6th place nephritis with 29,000 deaths.

Not only is heart disease the leading cause of death but it is a menace to all age groups. No age is respected. Let us look at this indiscriminatory potential killer more closely. At birth he may confront the newborn infant with any of the congenital malformations and, their consequences, if left untreated. Ascending the age scale to the 5-19 year bracket, rheumatic fever and its cardiac sequelae becomes the leading fatal disease in this group of young people. Beyond the age of 35 years cardiovascular disease outranks all other causes of death. After 45 years of age one out of every two deaths is caused by heart disease.

If we were to group these diseases, it would become apparent that congenital malformations account for only 2% of all heart disease while 90% of all heart disease can be attributed to rheumatic heart disease, coronary heart disease or hypertensive heart disease. Syphilitic heart disease is decreasing because of the use of penicillin. In an inverse ratio form, degenerative heart disease is increasing because the use of penicillin has promoted longevity. In the light of such information, it is difficult to discuss except very superficially, one field of cardiovascular surgery in the allotted time. For this reason, we shall only briefly touch on those conditions in which surgery plays a rehabilitative part and perhaps speculate about those conditions where surgery can play a greater part.

First, let us consider trauma to the heart partly because in this day of automobiles and speed, steering wheel crush injuries to the chest are common. The resulting contusions to the pericardial sac enclosing the heart and to the heart muscle are not unusual. Such pericardial or myocardial injury will produce either the symptoms of tamponade or infarction. If cardiac tamponade is suspected, aspiration is essential. Contusion is treated with 2-5 weeks of bed or chair rest.

Penetrating wounds of the heart are usually the result of stab and gunshot wounds. The presenting symptoms are those of cardiac tamponade; shock and often cyanosis. If unrecognized and untreated the end result is cardiac standstill. What is the treatment? Aspiration, transfusion and observation. If shock continues or recurs or aspiration fails, surgical intervention is the only treatment.

There is another type of cardiac tamponade of a chronic nature which is often forgotten—that of constrictive pericarditis. Its end result is as lethal as the acute type of tamponade. The treatment of this kind of cardiac tamponade is to surgically free the heart from its thick constricting pericardial shell.

There is no reason at this time to discuss congenital heart disease. All of us are aware of and grateful for the pioneer work done by Dr. Blalock in pulmonic stenosis. With the proven results of shunting procedures and the newer intracardiac approach of Brock, surgery has become the choice of treatment. However, the importance of an accurate diagnosis cannot be overstressed. An error may subject a child to a needless and sometimes fatal operation. Two laboratory procedures which greatly reduce this error are cardiac catheterization and angiocardiology.

Septal defects, both atrial and interventricular, stand on less firm ground, as evidenced by

the large number of surgical procedures devised and tried for an accurate closure.

In the field of acquired cardiac lesions, the most gratifying procedure is commissurotomy performed for patients with mitral stenosis. Every physician today is acquainted with the patient with mitral stenosis who after a mitral commissurotomy is now up and about, living an active and little restricted life. Even those less fortunate patients with degrees of mitral insufficiency are, on the whole, aided by cutting the valve commissures to produce a more nearly normal physiological valve leaflet.

Surgery for aortic stenosis has looked less convincing because of the high incidence of ventricular fibrillation at operation. With the newer technique of approaching the aortic valve from the aortic side this fatal complication has been eliminated and now the mortality and morbidity rates are rapidly decreasing.

The final field of cardiac surgery at present encompasses the coronary problem. Medically speaking and even with ideal care, all persons who develop coronary occlusion of one type or another are shown statistically to fall into one of 4 groups. 1) 25% will die of their first attack. 2) 25% will die within the first year. 3) 25% will die within a period of 5 years. 4) 25% will live 5 years or longer.

Medical treatment of coronary spasm and

occlusion is purely supportive in nature. It would seem that the urgent need is a revascularization of the ischemic heart muscle by surgical methods. There are several procedures in order of magnitude to meet the risk, but all strive for one effect; to increase the blood supply to the impoverished myocardium.

Beck's work in this field has been monumental. His abrasive procedures with burr and talc are aimed at abolishing the trigger mechanism of localized myocardial ischemia. His arterial anastomoses to the coronary sinuses attempts to develop a greater cardiac vascular reserve. Vineberg with his mammary artery transplant and the other types of cardiopexies all strive to bring blood from some other source to the heart. It is hoped that selective vagal resection will relieve coronary vasospasm and improve collateral circulation. All of these procedures await the test of time but those which have been performed throughout the past few years boast better results than the classical medical regimes today.

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DR. RIENHOFF: Thank you, Dr. Cowley.

Now last, but certainly not least, is Dr. John E. Miller, who will talk to us on Esophageal Surgery, and then if we have time, anyone who wishes to ask questions will send up questions and we will try to answer them.

SURGICAL ASPECTS OF DISEASES OF THE ESOPHAGUS

JOHN E. MILLER, M.D.

In the past 15 years there has been much progress in the surgical treatment of diseases of the esophagus. Much credit must be given to the development in the ancillary fields of surgery, such as chemotherapy, anesthesia and physiology, with improved knowledge of fluid, electrolyte and nutritional factors involved.

The esophagus is a fragile, tube-like organ and bears close anatomical relationship to vital organs as it traverses the mediastinum. It is without serosa covering, has fragile musculature and a fairly tough mucosa. Its blood supply is segmental and, although it is readily expansile circumferentially and retractile, it stretches down-

ward very little. Therefore, gentleness in technique, avoidance of tension on the suture line and minimal, but adequate, mobilization of the esophagus are important.

Diagnosis can be made readily in most instances if one maintains a sufficiently high index of suspicion as to the possible presence of esophageal disease. The most frequent and earliest symptom is that of difficulty in swallowing. Other symptoms are gaseous eructations, regurgitation, pain, loss of weight and strength, etc. Radiologic examination, with fluoroscopy, following the installation of contrast media is indicated in any patient having symptoms of possible esophageal origin. A negative radiologic examination does not rule out the presence of esophageal disease and, if symptoms persist or recur, the examination should be repeated and esophagoscopy performed. In an occasional case exploratory thoracotomy will be necessary.

There are certain general preoperative and postoperative factors that merit mention here. Many of these patients are not seen until nutritional and fluid volume deficiency exist. This should be corrected, insofar as possible. Aspirational pneumonia and atelectasis are not infrequent accompaniments of esophageal disease and should be treated. Liberal use of appropriate antibiotics systemically and orally should be started several days preoperatively and continued postoperatively for the control of infection. Most patients with esophageal disease are in a group in which physiological impairment of other organs is to be expected and these patients tolerate excessive fluid volume replacement poorly. Early mobilization of the patient and resumption of oral alimentation within the first few postoperative days is desired.

Congenital lesions of the esophagus are being recognized with increasing frequency. Atresia of the esophagus with fistulous communication to the trachea is perhaps the most common. It should be suspected in any newborn infant that has excessive salivation, choking spells with cyanosis, which is aggravated on feeding and is

followed by regurgitation of the feeding then or shortly thereafter. The diagnosis can be confirmed by inserting a soft 8 or 9 French rubber catheter in the posterior pharynx and obstruction will be encountered at a distance of approximately 10 cm. from the upper gum margin. Further confirmation can be had by radiological examination with fluoroscopy in which 1 or 2 ccs. of Lipiodol are instilled into the posterior pharynx and the upper esophageal segment is visualized. Barium mixture should not be used. The treatment is surgical ablation of the fistulous communication, with early establishment of esophagogastric continuity as soon as proper surgical preparation of the patient has been effected. Most of these infants are premature, have varying degrees of nutritional and fluid depletion, invariably have aspirational pneumonitis and atelectasis, and not infrequently, have other associated anomalies. Nutritional and fluid depletion is corrected but overhydration is carefully avoided. Infection is controlled by the liberal use of antibiotics and atelectasis can usually be relieved by the proper positioning of the patient and frequent transpharyngeal aspiration by a soft rubber catheter. An operative technique is illustrated.

Trauma of the esophagus is not infrequently encountered. External trauma to the esophagus is of such a nature in its occurrence that thoracotomy is usually necessary and it is appropriately treated. Perforations occur most commonly in the upper third of the esophagus and instrumentation is the most frequent cause. Any patient having acute onset of severe substernal or epigastric pain, with rapid development of shock accompanied with increased dyspnea and cyanosis, should be a suspect of esophageal perforation. In the presence of recent trauma or a regurgitation of blood, it is practically diagnostic. It is further confirmed if air can be demonstrated in the tissues of the neck, mediastinum or pleural cavity. It can also be demonstrated radiologically following swallow of a few ccs. of Lipiodol. Again, barium mixture should not be

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¹Albertson, H. A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N. Y., 1955, pp. 599-602.

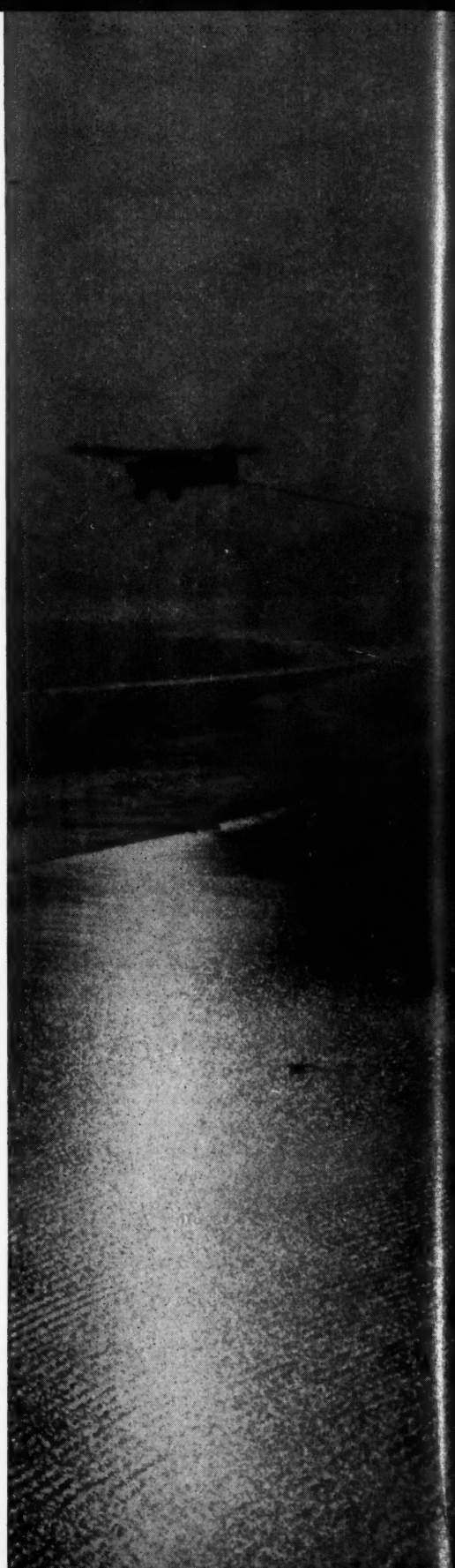
²Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.



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used. With the exception of the occasional small and relatively clean perforation of the esophagus, secondary to operative instrumentation, which is recognized early, treatment is promptly instituted at a stage when diagnosis is based mainly on symptomatology and in the absence of findings indicating gross contamination or involvement of contiguous structures, the recommended treatment is thoracotomy with repair of the perforation and drainage of the surrounding area. Shock here is progressive and, although immediate steps should be taken to combat it, one should not delay surgery for its response. Cases with well developed symptomatology almost invariably result fatally without surgical treatment.

Symptomatic diverticuli are most commonly of the pulsion type and originate most frequently in the hypopharyngeal area. Occasionally they are encountered just above the diaphragm (epiphrenic). In addition to dysphagia, these patients also complain of malodorous eructations, regurgitation of undigested food on lying down, noisy swallowing and others. Diagnosis can usually be made on radiological examination following swallow of radio-opaque substances. Treatment in other than the very small relatively asymptomatic diverticulum, is resection of the sac with repair of the esophagus and is usually accomplished in one stage.

Esophageal varices are usually not suspected until massive bleeding occurs. They are usually a manifestation of some obstruction in the portal venous system. They may be demonstrated by x-ray examination with contrast media but are more frequently demonstrated by esophagoscopy. The most effective treatment is portosystemic venous anastomosis in properly selected cases. Included among other forms of therapy are balloon tamponade for the immediate control of hemorrhage and transthoracic-trans-esophageal suture ligation of the varices.

Cancer is one of the most frequently encountered diseases of the esophagus, and also, one of the least responsive to our present day methods

of therapy. Its incidence of occurrence is approximately 10 per cent of all gastrointestinal malignancies. It occurs most frequently in patients of the older age group. Symptomatology is similar to that of other esophageal diseases and diagnosis is made in the usual manner and confirmed by pathological examination of tissue removed by biopsy at esophagoscopy. At the present time, if treatment is to be directed toward cure, it must be surgical. As in all malignancies, it is important that the diagnosis be made early if improved surgical results are to be obtained. It is pertinent to remind that the first successful one such transthoracic-esophageal resection for cancer of the esophagus with direct esophago-gastric anastomosis was performed by Adams and Phemister in 1938 and, as of recent report, the patient is still alive and well. Surgical treatment today is directed toward ablation of the malignant disease with re-establishment of esophago-gastro-intestinal continuity. The newer modalities of x-ray treatment are yielding increasingly good palliation but their ultimate place in the treatment of this disease must await further evaluation.

Other malignant tumors of the esophagus are encountered with much less frequency and do not sufficiently vary in their characteristics or treatment to merit specific mention here.

In conclusion, an attempt has been made to briefly review the principal diseases of the esophagus that are amenable to surgical treatment; to mention some of the diagnostic features and to indicate the prevailing concepts of treatment.

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DR. RIENHOFF: I'm sorry to rush Dr. Miller, but the time is getting on. It is 10:20 and I am sure that the members of the Panel will be very happy indeed to answer questions.

I want to make one point that Dr. Miller didn't mention but Dr. Bahnson did. Briefly, it was a case of Dr. McLanahan's, i.e., rupture of the esophagus in a relatively young man after an attack of vomiting that

constituted a very difficult diagnostic problem. I think Dr. McLanahan, who is sitting back there will remember him very well. There was a rupture of the lower end of the esophagus, which is very unusual. At least, I have never seen one, but I am going to hold it in mind from now on, and I just mention that for the sake of completeness.

Are there any questions anyone would like to ask any members of the Panel?

I am sure I speak for one and all of us when I say we enjoyed this very comprehensive coverage of this field of Thoracic Surgery. I am sorry Dr. Bahnson didn't show one of his aneurysmal grafts, but he thought it wasn't included in mediastinal surgery.

SURGICAL TREATMENT OF ANEURYSMS OF THE MIDDLE CEREBRAL ARTERY

REPORT OF TWO CASES*

JAMES PETER MURPHY, M.D., F.A.C.S.†

Subarachnoid hemorrhage is a clinical entity of sudden appearance, attended by severe morbidity and a high incidence of fatality, which appears to be of increasingly frequent occurrence. During recent years, the problems of differential diagnosis, management and definitive treatment of patients who have sustained attacks of subarachnoid hemorrhage have come to lie within the province of neurosurgery. This is true chiefly because in the majority of cases of this disorder rupture of a congenital arterial aneurysm of the circle of Willis is the cause of subarachnoid bleeding. Such an event can be proved only by intracranial angiography, a neurosurgical technic, and the control of the leaking aneurysm is accomplished most logically by surgical methods. Other sources of subarachnoid hemorrhage, such as arteriovenous anomalies of the brain, intracranial neoplasms and some spontaneous hypertensive hemorrhagic apoplectic strokes are also neurosurgical conditions.

Mortality statistics favor the neurosurgical treatment of ruptured intracranial aneurysm as

compared with the results of conservative management; in a large reported series, the over-all death rate in 752 patients treated medically was forty-eight per cent, whereas only fourteen per cent of patients treated surgically died.⁴ The widespread application of angiographic investigation to more and more cases of intracranial bleeding of whatever suspected cause is revealing an increasing number of supposedly "medical hemorrhages" to be actually the result of rupture of aneurysms, arteriovenous anomalies or other conditions amenable to surgical control. Although in almost all instances of spontaneous subarachnoid hemorrhage initial bleeding cannot be stopped directly but must subside as an effect of natural reparative processes, the aims of neurosurgery thereafter are to localize the ruptured vessel, prevent predictably certain future episodes by eradication or thrombosis of the vascular lesion, and to evacuate intracerebral or subdural hematomas.

Seventy-five per cent of all intracranial arterial aneurysms responsible for subarachnoid hemorrhage arise from the terminal internal carotid artery or its proximal branches. Therefore, the majority of these small but dangerous congenital sacculations are accessible for diagnosis by carotid arteriography and are amen-

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able to surgical control by intracranial clipping or ligation of the cervical carotid artery. Although aneurysms in specific locations tend to produce characteristic neurologic findings, clinical examination alone is not sufficient to permit adequate localization. Only angiography is reliable and bilateral carotid injections should usually be performed to eliminate the possibility of multiple aneurysmal formation which may preclude surgical treatment.

Aneurysms of the middle cerebral artery are uncommon; less than one hundred instances have been described in the literature. The following two cases are reported to add to the series, to emphasize the paucity of neurologic findings when even such a major cerebral artery is involved by aneurysm, and to contrast the two methods of neurosurgical therapy of intracranial arterial aneurysms currently in practice.

CASE REPORTS

1. K.H., a 40 year old married white female, was admitted to the Suburban Hospital, Bethesda, Maryland, under the care of Dr. George Gray. Two days previously the patient had sustained a severe attack of generalized headache, maximal in the occipito-cervical region but radiating frontally. Spinal puncture revealed grossly bloody fluid under increased pressure (250 mm. of water). The pupils were miotic and there were no other neurologic findings other than signs of meningeal irritation. Bilateral carotid arteriography on June 6, 1954 disclosed a berry aneurysm, 5 mm. in diameter, arising from the right middle cerebral artery 2 cm. distal to its origin (Figure 1). The cerebral vessels generally appeared to be sclerosed.

Intermittent external compression of the right common carotid artery in the neck was extended until the patient could tolerate 20 minutes of complete occlusion as tested by obliteration of the temporal pulse without signs of cerebral ischemia. On June 14, 1954 the right common carotid artery was doubly ligated under local

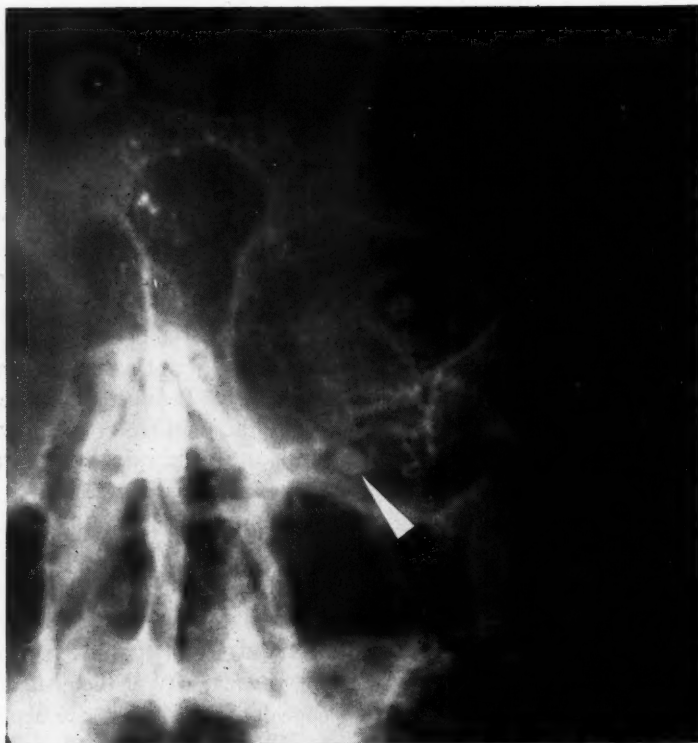


FIG. 1. Antero-posterior carotid arteriogram, Case 1. Small, round aneurysm (arrow) arising from the right middle cerebral artery. (Figure reversed.)

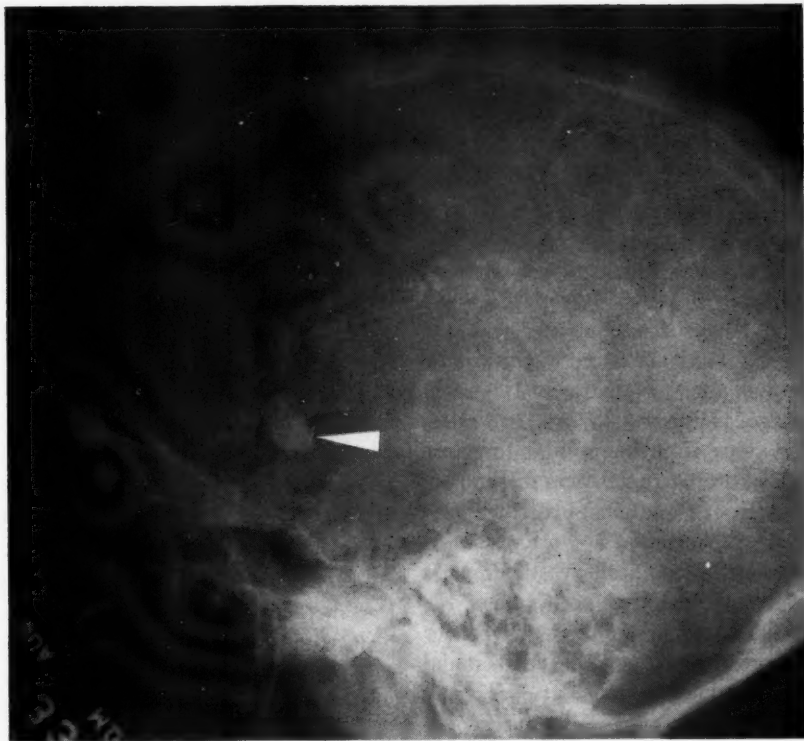


FIG. 2. Lateral carotid arteriogram, Case 2. Large, irregular aneurysm (arrow) depending from the right middle cerebral artery.

anesthesia after visualized complete temporary occlusion of the vessel for 20 minutes was found to be safe. During the next several days episodes of temporary left hemiparesis occurred briefly and usually at night; cerebral arteriosclerosis as verified by angiography was felt to be responsible, and papaverine, heparin and intravenous histamine were administered in treatment. The patient was discharged on June 24, 1954, the twenty-first hospital day.

Aside from another brief attack of hemiparesis during a systemic viral illness, the patient has been well since, has had no further episodes of subarachnoid hemorrhage and has resumed all of her usual activities. The neurologic examination is normal.

2. J.L.B., a 40 year old white male, was admitted to the Suburban Hospital on November 29, 1954 having sustained an attack of subarachnoid hemorrhage five days before. The spinal fluid was bloody and under increased pressure, the neck was stiff, Kernig reflexes were positive, there was pain behind the right eye and the left arm was numb but not weak. Carotid arteriography revealed a large aneurysm arising from the right middle

cerebral artery 3 cm. lateral to the circle of Willis (Figure 2).

External compression of the right common carotid artery was undertaken to the point of adequate tolerance, as in Case 1, but because of the peripheral location of the aneurysm it was decided to approach the lesion directly. On December 6, 1954 under general anesthesia a right frontotemporal craniotomy was effected. All surgical precautions to prevent uncontrollable hemorrhage from the lesion were employed. Arfonad was injected to produce controlled hypotension during operation. The common carotid artery was exposed and encircled with a tape for occlusion, which fortunately proved not to be necessary. The tip of the right temporal lobe was excised so that a silk noose could be placed around the middle cerebral artery, after the method of Campbell and Burkund.²

Incision of the right frontal lobe revealed a huge hematoma to be surrounding the aneurysm. After evacuation of the clot the noose around the middle cerebral artery was tightened temporarily and the aneurysm was thoroughly clipped at its base. All minute bleeding points

were controlled, the bone flap was replaced, and the incision was closed.

The postoperative course was featured by severe paresis of the left lower face and upper extremity. The patient was discharged on December 21, 1954, the twenty-fourth hospital day. Physiotherapy and spontaneous recovery of function improved the strength of the left side and in June, 1955 the patient was able to play golf and return to his usual occupation. The left hand is somewhat weak and clumsy.

DISCUSSION

Frankel and Alpers³ have pointed out the difficulty of implicating aneurysm of the middle cerebral artery as a specific source of subarachnoid hemorrhage, as was true in these two cases. The localizing value of angiography is therefore emphasized. Concerning contrasting methods of surgical treatment of two almost exactly similar vascular lesions of the brain, a short resume is in order. Experimental surgical investigations in the human have proved that occlusion of the common carotid artery in the neck will reduce intravascular pressure in a small intracranial arterial derivative almost as much as does direct clipping of the parent vessel.¹ Moreover, long-term follow-up of patients with intracranial aneurysms treated by ligation of the cervical carotid artery indicate that complete control of such lesions may be thus effected, as in Case 1. Reduction of pressure-head evidently allows thrombosis in the congenital arterial sac.

On the other hand, Petit-Dutailais and Pittman⁵ reporting personal experiences with seven cases of middle cerebral aneurysm and the results of treatment of seventy-five other patients from the literature, contrast a mortality rate of fourteen per cent when the anomalies were clipped intracranially with a fatal outcome of twenty-two per cent of cases when carotid ligation was employed. These authors favor the direct approach to aneurysms of the middle cerebral artery.

SUMMARY

Two cases of congenital arterial aneurysm of the middle cerebral artery which caused sub-

arachnoid hemorrhage are reported. Both were verified by carotid angiography. In one instance, ligation of the ipsilateral common carotid artery was undertaken for presumed indirect control of the lesion; the patient is without neurologic disability. In the other case, the aneurysm was clipped directly and an intracerebral hematoma surrounding the congenital sac was evacuated. This patient is definitely cured, but retains a slight contralateral hemiparesis.

Experimental evidence indicates that ligation of the cervical carotid artery will reduce pressures in small intracranial vessels sufficiently to cause thrombosis in aneurysms. But only intracranial surgery will permit direct, visualized obliteration of these lesions and removal of perianeurysmal intracerebral hematomas. Individual analysis of each case of ruptured intracranial aneurysm allows a logical decision as to the method of surgical treatment. Proximal ligation of the cervical carotid artery is indicated if an aneurysm lies on or near the terminal carotid at the circle of Willis and if there is no angiographic evidence of intracerebral hematoma; intracranial clipping is in order if the aneurysm arises from a peripheral branch of the carotid or if displacement of vessels in the arteriogram reveals the presence of a blood clot in the brain.

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CHANGING IDEAS IN THE DIAGNOSIS AND CONTROL OF HYPERTENSION*

CAROLINE BEDELL THOMAS, M.D.†

Great changes are taking place in our attitudes toward hypertension. Not many years ago, the doctor felt uneasy when he found a patient with high blood pressure, because he knew of *no* specific form of treatment for it. Today, he often feels even *more* uneasy,—there are so many therapeutic measures currently advocated, that he is uncertain which, if any, of the various diets, drugs and operations will help a particular hypertensive patient. On the one hand, he is afraid he will seem old-fashioned if he does not prescribe something specific. On the other, he has heard rumors of unfortunate reactions, which make him hesitate to branch out into new forms of treatment. What should he do? There is no simple answer to this perplexing question, but I should like to suggest a series of guideposts which may prove useful in appraising various kinds of hypertensive patients.

As soon as a physician encounters a patient with elevated blood pressure, he may obtain some perspective on its significance by attempting to answer the following questions to his own satisfaction:

1. Is the hypertension early or late?
2. Is it asymptomatic, or accompanied by definite symptoms of hypertension?
3. Is it of the "essential" variety, or is it a manifestation of some other disease process?
4. Is its course malignant or benign?
5. What is the attitude of the patient toward his illness?
6. Is there evidence of events in the recent

past disturbing to the patient which may have produced increased elevation of blood pressure and exacerbation of symptoms?

It is usually necessary to see the patient several times before the answers to these questions are clear to the physician. Meanwhile, specific therapy should be withheld, and the less said about the patient's blood pressure the better. It is hard to avoid some expression of concern or alarm on discovering an extremely high blood pressure, but it is of the utmost importance for the patient's future welfare to do so. Remember that the patient is inwardly tense and upset at the first visit and the blood pressure may be far higher than usual. In fact, the initial pressure is often close to maximal pressure, comparable to the peak of the cold pressor test. Many patients, particularly women, whose hypertension at first sight seems severe, with blood pressure levels above 220/140 mm.Hg, may subsequently be found to have daily levels in the range of 150-170/90-100 mm.Hg with little or no treatment aside from reassurance. The patient's questions should be met, kindly but firmly, with, "Wait until we have assembled all the facts—then I shall go over the whole story with you."

Let us now consider some of the specific types of hypertension that we frequently encounter. First comes the young person in the twenties, thirties or early forties, whose hypertension is discovered during a routine examination for a job, insurance, or military service. New drugs are the last things to think of in such a case, and the attitude of the doctor toward the problem is all important (Table I). Despite the fact that he feels well, the patient suddenly seems threatened with loss of health and security from a mysterious ailment. All too often he knows of

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TABLE I
Control of Early Asymptomatic Hypertension

DO:	DO NOT:
1. Be understanding, friendly, thorough.	1. Reject
2. Attend to minor health problems.	2. Ignore
3. Discuss pattern of living and goals.	3. Scare
4. Encourage rewarding activities.	4. Forbid
5. Rule out reversible hypertension.	5. Neglect

TABLE II
Reversible Hypertension—Coarctation of the Aorta

In hypertensive patients under 40, look for:
1. Feeble or absent pulsation in arteries of legs and feet.
2. Decreased pulsation of abdominal aorta.
3. Notching of ribs, absent aortic knob by X-ray.
Confirm by fluoroscopy, special X-rays such as aortograms.
Treatment: Resection of coarcted portion of aorta.

an older relative who has suffered a stroke or is otherwise incapacitated from cardiovascular disease and immediately envisions a similar fate for himself. The doctor who tells his patient to "forget it" consigns him to a limbo of continuing doubts and fears which only serves to perpetuate the elevation of blood pressure. A careful medical appraisal is the best antidote to such morbid imaginings, and offers an unparalleled opportunity to educate the patient about his health assets and liabilities in a friendly, matter-of-fact way. At the same time certain special tests should be carried out to make sure that one of the "reversible" forms of hypertension is not present, for if this important step is postponed, the patient may not return to a doctor until irreparable damage to brain, heart or kidney has occurred.

Coarctation of the aorta should always be kept in mind during the physical examination, for this condition may be readily recognized if the physician's index of suspicion is high (Table II). Diminished or absent arterial pulsations in the legs and abdominal aorta stand in sharp contrast to the forceful pulsations in the vessels of the arms and neck. The blood pressure in the arms may be high or only slightly elevated, while the leg pressures are far lower. Intercoastal pulsations and a systolic murmur over the back

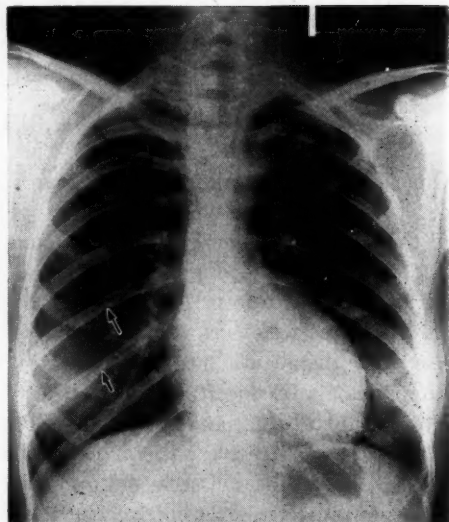


FIG. 1. Coarctation of the aorta in a woman of 18 showing the characteristic notching of the ribs (see arrows). The left ventricle shows early hypertrophy, yet the aortic knob is inconspicuous.

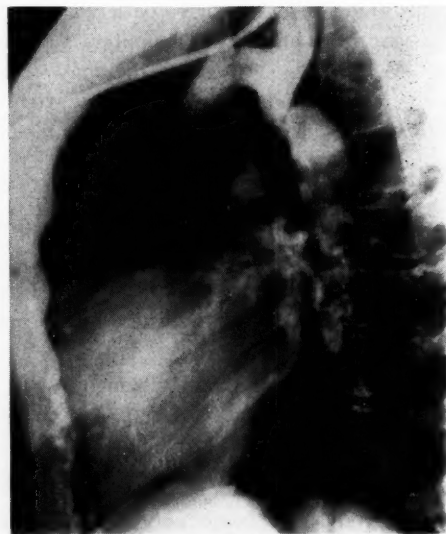


FIG. 2. Aortogram in left anterior oblique position with catheter in brachial artery, demonstrating aortic coarctation at the usual site just distal to the origin of the left subclavian artery at the junction of the transverse and descending portions of the aorta. (Same patient as in Figure 1.)

may or may not be present. The diagnosis of coarctation should be confirmed by X-ray (Figure 1). Notching of the lower ribs is usually present after the age of 12, indicating the presence of collateral circulation. The aortic knob is inconspicuous or absent. Occasionally an E-shaped notch may be seen on the descending aorta which indicates the actual site of coarctation. The heart is enlarged in more severe cases. An angiogram defines the exact site and extent of aortic narrowing (Figure 2). When the diagnosis is definite, operation should be urged even in the absence of symptoms. Because of the high incidence of cardiac failure, rupture of the aorta, cerebral hemorrhage and bacterial endocarditis the life expectancy of unoperated patients is short, the average age at death being about 30 years.

Unilateral renal disease as a cause of hypertension is all too readily overlooked (Table III). While a history of abdominal pain or pyelitis may give a clue, the disease process may be relatively silent or remote in time. The healthy kidney hypertrophies and carries on so well that ordinary renal function tests are normal. For these reasons, most hypertensive patients in the younger age groups should have an intravenous pyelogram. If one kidney appears abnormal, retrograde pyelography and differential function tests should be carried out (Figure 3). An aortogram may show a narrowing or occlusion of one



FIG. 3. Intravenous pyelogram showing advanced unilateral renal disease, with a functionless right kidney containing a large staghorn calculus. The patient, a woman of 37, gave a history of passing a handful of kidney stones at 18. She had had six pregnancies with increasing elevation of blood pressure and repeated attacks of pyelonephritis, but X-rays of the kidneys had never been ordered. At the time of this pyelogram, renal function was normal by ordinary tests. The hydronephrotic right kidney was removed; chronic pyelonephritis had led to complete destruction of kidney tissue. Although improvement in blood pressure levels was noted, it is probable that operation came too late to reverse the hypertensive process in this patient.

of the renal arteries. Even if the initial intravenous pyelogram appears normal, in cases where the onset of hypertension is recent and its progression rapid, a second intravenous pyelogram taken several months after the first may reveal definite shrinkage of one kidney. While nephrectomy does not reverse the hypertension in every instance of unilateral renal disease, there are now many well-authenticated cases on record in which the blood pressure has fallen to normal after operation and has remained there for months or years.

Pheochromocytoma, a tumor of the adrenal medulla, may cause either paroxysmal or sustained hypertension through the secretion of excessive epinephrine-like substances (Table IV). The paroxysmal form is the more usual, and is characterized by *attacks* in which the patient suddenly feels apprehensive and notes the onset of palpitation, headache, tremulousness and other manifestations of adrenal medullary over-

TABLE III

*Reversible Hypertension—Unilateral Renal Disease
(From Pyelonephritis, Infarction, Partial Arterial
Occlusion, etc.)*

Usually clinically indistinguishable from essential hypertension.

Suggestive points:

- History of abdominal pain or pyelitis.
- Rapid progress, high diastolic levels.
- Retinopathy, headaches, convulsions.

Rule out by intravenous pyelogram.

If IVP positive, confirm by:

- Retrograde pyelography.
- Differential function tests.
- Arteriography.

Treatment: Nephrectomy.

TABLE IV
Reversible Hypertension—Pheochromocytoma

Paroxysmal Hypertension or more:	Sustained Hypertension
Look for story of attacks of one or more:	Mimics essential hypertension
Headache	May have:
Shakiness	High BMR
Palpitation	Pallor
Sweating	Tachycardia
Vomiting	Epigastric discomfort
B.P.: Rises during histamine test (may be hazardous)	Diabetic glucose tolerance curve
	Falls during benzodioxane, dibenamine, or regitine test
Treatment: Exploratory laparotomy; removal of tumor or tumors.	

activity. The attacks may or may not be severe. The milder types are sometimes mistaken for paroxysmal tachycardia, migraine headaches, or anxiety attacks. Frequent observations of the patient's blood pressure may reveal great variations. Occasionally sustained hypertension clinically indistinguishable from essential hypertension may be produced by this tumor. The differential diagnosis in such circumstances is most frequently accomplished by the intravenous injection of a test substance such as benzodioxane or regitine which results in a sharp drop in blood pressure in contrast to a predominantly pressor response in patients with essential hypertension (Figure 4). Other procedures sometimes helpful in establishing the diagnosis include plain X-rays of the abdomen, laminograms with or without perirenal air insufflation, and the injection of histamine or mecholyl to reproduce the attacks in the paroxysmal type. The latter tests should be carried out with caution, and massage of the suspected tumor area as a means of precipitating an attack is considered to be too dangerous. Tremendous elevation of blood pressure with resulting hemiplegia or death has been known to occur. Treatment consists in excision of the tumor tissue, which restores the blood pressure to normal and abolishes the attacks. Recurrences are infrequent, as the tumor is usually benign. However, because the tumor may occur bilaterally or in the chromaffin

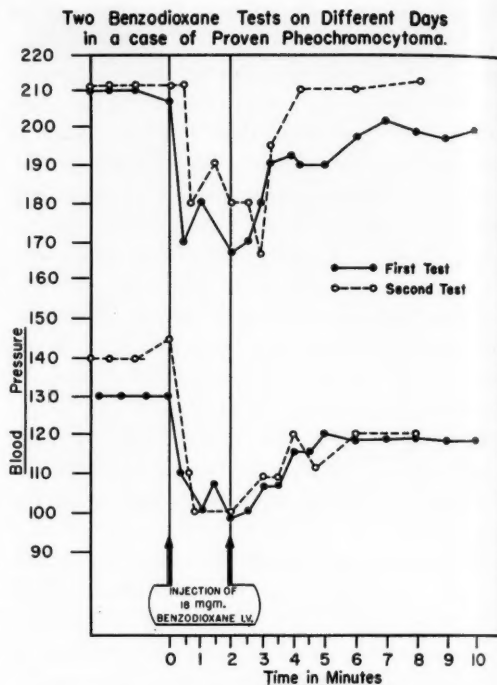


FIG. 4. Two positive benzodioxane tests on the same patient showing strikingly similar depressor responses on different days. The patient was a 35 year old white man who gave a history of sustained hypertension for over five years. At operation the pheochromocytoma was found wrapped around the right renal pedicle.

system along the aorta entirely outside of the adrenal glands, an exploratory laparotomy by the anterior approach is usually preferred. The operation is not without hazard, and should only be performed by a surgeon who is fully aware of the ways of protecting the patient from precipitous changes in blood pressure.

The last form of hypertension which is truly reversible occurs in those cases of Cushing's syndrome associated with tumors or bilateral hyperplasia of the adrenal cortex. These patients present a striking appearance, with a florid moon-shaped face, varying degrees of acne and hirsutism, a fat pad at the base of the neck which, taken with the obese trunk and slender extremities, is termed the "buffalo type" of obesity (Figure 5). The muscles are weak and



FIG. 5. A typical patient with Cushing's syndrome from adrenal cortical hyperplasia. (Through the courtesy of Dr. Samuel P. Asper, Jr.)

the skin very thin and friable, with purple abdominal striations. If metabolic studies confirm the diagnosis, operative removal of the adrenal tumor may result in complete recovery of the patient. The discovery of cortisone has recently made it possible to operate on patients with adrenal cortical hyperplasia as well. Sub-total or total adrenalectomy followed by cortisone replacement therapy to prevent adrenal insufficiency have been successful in restoring such patients to health.

Patients with essential hypertension of moderate degree, with resting blood pressure levels rarely higher than 200/120 mm., let us say, often have vague complaints such as poor sleep, irritability or intermittent headache which are annoying but not incapacitating (Table V). Such patients should be carefully watched, however, for a few may be in the progressive phase of the disease in which vigorous measures will soon be needed, and all will benefit from a physician's care. Heart X-ray, electrocardio-

gram, studies of kidney function and of retinal fundi should be recorded as a baseline for evaluation of the course of the disease before instituting treatment. Initial therapy for these patients should be simple—a judicious combination of sedation, weight reduction and such additional measures as are suited to the patient's needs (Table VI). Digitalization may decrease palpitation and dyspnoea on exertion; elevation of the head of the bed on blocks relieves morning headaches.

As the physician becomes familiar with the patient's life problems, he is able to lighten the burden through discussion and sympathetic understanding. It is better to assist the patient to streamline his own activities than to impose authoritarian restrictions. The patient may be encouraged to continue the activities which give him satisfaction and, indeed, to take up new recreational interests, while cutting down on whatever produces strain, anxiety or frustration. Through such a constructive approach,

TABLE V
Control of Moderate Hypertension

With or without: headache, nervousness, insomnia, irritability, palpitation, fatigue, dyspnoea

DO:	DO NOT:
1. Insist on frequent visits.	1. Lose track.
2. Evaluate heart and kidneys.	2. Postpone tests.
3. Watch retinal changes.	3. Omit consultations.
4. Start simple treatment.	4. Curb drastically.

TABLE VI
Control of Moderate Hypertension

Useful Measures
1. Decrease stresses—streamline activities.
2. Assist relaxation—phenobarbital t.i.d.
3. Promote sleep—bedtime sedation.
4. Reduce weight—low calorie diet.
5. Combat headache—head of bed on blocks.
6. Improve cardiac reserve—digitalization.

rather than saying "don't" at every turn, the hypertensive patient gradually learns to relax and change his point of view, with lasting benefit to his blood pressure.

If after a period of weeks the patient still suffers from his complaints, then for the first time specific anti-hypertensive drugs should be tried. The two best suited for patients with moderate hypertension are thiocyanate and various preparations of Rauwolfia (Table VII). These drugs have certain similarities. Both relieve headache and promote sleep and relaxation. Given orally, there is no immediate hypotensive reaction; their effects appear gradually over a period of weeks, and disappear slowly after withdrawal of the drug. Symptomatic improvement may be more marked than the reduction in blood pressure. Their pharmacological action is not well understood; neither produces postural hypotension nor diminishes the cold pressor response. Although perhaps Rauwolfia is effective in a somewhat smaller percentage of patients, it is today the drug of choice, chiefly because there are fewer dangers from overdosage. To give thiocyanate safely, the dosage must be regulated by the blood level of the drug. The chief side effects of Rauwolfia

TABLE VII
Specific Therapy for Patients with Moderate Hypertension

Thiocyanate	Rauwolfia serpentina	Similarities
Effective in majority	Effective in minority	Given orally for months or years
Gives sense of well-being	Produces bradycardia	Reduce B.P. -30/20 mm. (average)
Dosage regulated by blood level; optimal range 8-12 mgm. %	No blood levels needed	Promote sleep, relaxation
May be toxic above optimal range	Few side effects	Relieve headache
Contraindicated in elderly patients, renal disease	Not helpful in severe cases	Action appears and disappears slowly

are somnolence, fatigue and weakness, which may be bothersome at first but usually wear off in several weeks. Nasal stuffiness, which is readily controlled by antihistaminics, diarrhoea, weight gain, and oedema are less common. Recent reports of occasional depressive reactions make it advisable to be on the alert and to stop the drug promptly if suggestive signs of this disorder appear. The bradycardia produced by Rauwolfia undoubtedly contributes to the overall cardiovascular improvement, particularly in those patients with a rapid heart rate originally.

The severe forms of hypertension usually present themselves with some form of crisis and under those circumstances care in the hospital is most often necessary (Table VIII). High diastolic pressure levels go hand in hand with high cerebrospinal pressure levels, and one or more of the following symptoms may be present: Dizziness; headache, often severe; blurring of vision or loss of vision; nausea and vomiting; weakness and prostration. The fundi may reveal early choking of the disks, and in the presence of papilledema we recognize the malignant phase of hypertension. Most authorities on hypertension consider that the term "malignant hypertension" should be reserved for those cases in which papilledema is present, with or without diminution in renal function. If such

patients are found early enough, renal function may be relatively intact, but it may be expected to deteriorate rapidly over the next few weeks or months. Bed rest and sedation are not active enough treatment for these people whose life expectancy is short indeed. Fortunately, we have today a variety of treatments at hand to use as tools in the reduction of blood pressure (Table IX). All the measures listed are able, in certain patients and under certain conditions, to bring blood pressure to normal or nearly normal for periods of weeks, months, or years. However, it is impossible to predict *which* patient will do well on *which* type of therapy or indeed whether a given patient will do well on any therapy. Each patient must be given a clinical trial under careful observation, first with one procedure, then adding others or changing if toxic symptoms arise. This morning I have not time to discuss dosages or exact procedures, but will give you a glimpse into the good and bad effects of each one.

Hexamethonium and its recent relative, pentolinium tartrate, are ganglionic blocking agents which affect not only the sympathetic nervous system, but also the parasympathetic nervous system. The latter characteristic may produce such unfortunate reactions as difficulty in voiding, actual urinary retention, constipation or paralytic ileus, so that the drugs are not benign, although they are not "toxic" aside from the effects produced through their pharmacological actions. There may be a profound fall in blood pressure within an hour or so of administration either intravenously, orally, or subcutaneously when the patient is endangered by symptoms of postural hypotension and may actually faint unless he remains recumbent. The effects wear off rapidly and another dose needs to be given in four hours to six hours if lowered pressure is to be maintained. Patients receiving one of these ganglionic blocking agents over a long period of time must be cooperative and responsible. Either the patient or a member of the family should be trained to take his blood pressure before every

TABLE VIII
Severe Forms of Hypertension

Hypertensive crises	Benign hypertension with high diastolic levels
Hypertensive encephalopathy	Benign hypertension with cardiac or cerebral complications
Toxemia of pregnancy	Malignant hypertension
Terminal hypertension with renal insufficiency	

TABLE IX
Therapeutic Measures Available for Controlling Severe Hypertension

Sympathectomy	Hydrogenated ergot alkaloids (I.M.)
Sodium-free diet	Veratrum viride (I.V., Oral)
Rice diet	Hydralazine (I.V., Oral)
Pyrogens	Hexamethonium (I.V., Sub-Q, Oral)
Adrenalectomy	Combinations

dose of medicine, in order to regulate the dosage. Since hypertension may be expected to be present for ten or twenty years, the need for such constant regulation over the years has a great many disadvantages. Moreover, the patient tends to develop a tolerance to these drugs after several months. Accordingly, the greatest usefulness of the ganglionic blockers at present is to help reduce high blood pressure levels in the initial period of treatment. Hydralazine likewise should be given every four hours and blood pressures watched constantly around the clock. In addition, if it is given in large doses over a period of months two very undesirable syndromes may appear, namely, rheumatoid arthritis and lupus erythematosus. Accordingly, it is wise to leave the use of hydralazine to those prepared to study it intensively. The veratrum preparations are useful in the acute phase but often produce vomiting at such a low threshold that they are not very satisfactory. Rauwolfia can be combined with some of the new drugs with good results. It takes patience to work out the exact therapeutic program where combinations of drugs are used.

Regarding the dietary treatment of hypertension, both the rice diet and the low sodium

diet are extremely difficult to manage. Low sodium diets only render the patient hypotensive when he ingests less than a gram of salt a day. Not only is this an extremely hard diet to adhere to, but a dangerous one if there is poor renal function; it may precipitate uremia in older patients. The rice diet is most monotonous, although Dr. Kempner has had brilliant results in reversing the severe effects of hypertension in patients who have lived under his direction over a period of months. Few others have used it with success. Low fat diets should be considered for patients with atherosclerosis, high blood cholesterol levels or obesity.

We now come to sympathectomy, which at the present time is not in vogue. However, as a person who has watched many patients go through their sympathectomies and come out on the other side, most of these ten years ago, I consider that thoraco-lumbar sympathectomy of the Smithwick type presents the most practical solution to severe hypertension for many patients. In my experience the majority obtain real improvement in their functional capacity to work, and although the blood pressures may not be entirely normal with the patient at rest, there is little question but that the mean blood pressure is improved when the patient is active and at work in the upright position. I can think of one man who had a sympathectomy ten years ago while in his 30's with a diastolic pressure approaching 140, which is supposed to have ominous significance. He is now at the head of the Point Four Program in Afganistan, flies around the world and does very well. Another who, after two sympathectomies, the first of the Adson and the second of the Smithwick type, twelve and ten years ago, is now working hard in the West Indies, has raised a family there and has none of the symptoms which brought him here from the West Indies at the age of 24 with excessively high diastolic levels. And there are many more. Sympathectomy is worth considering for each patient. Just as sometimes surgical and sometimes medical measures are

TABLE X
Control of Arteriosclerotic Hypertension
Patients over 55 or 60; relatively low diastolic pressure;
wide pulse pressure; peripheral arteriosclerosis.

Use	Do Not Use
Moderation of {activities smoking	Sodium-free diet
Low calorie diet; no free salt	Thiocyanate
Sedatives Digitalis	Drastic hypotensive drugs
Theobromine Laxatives	Sympathectomy

helpful in peptic ulcer, so with hypertension. The patient who is not going to be constantly under an alert physician's care and the one who is impatient about taking care of himself, perhaps get the best effect from this form of treatment. Adrenalectomy is only recommended for a few selected patients where research facilities are available. It has been shown to reverse the hypertensive process in some patients who did not have good effects from sympathectomy as well as in those who never had that operation.

Finally, I want to remind you that little of the discussion so far applies to patients over the age of fifty-five or sixty. These are the people who have a wide pulse pressure, relatively low diastolic pressure and arteriosclerosis of the peripheral arteries and aorta. Many such patients may live quite comfortably for ten or fifteen years with very little regulation and it is extremely important not to overtreat them, but to maintain their normal activities and environment for as long as possible (Table X). The best regime for them includes guidance as to moderation of activities, and as to giving up smoking where any coronary or anginal complications exist, a diet to reduce weight with ordinary salt in the cooking but no additional salt, and the judicious use of sedatives, laxatives and digitalis with occasional theobromine preparations. It is important to be sure not to make them *worse* by prescribing a sodium-free diet, thiocyanate (which is poorly excreted and may attain dangerously high levels in the blood), or drastic hypotensive drugs. Sympathectomies and adrenalectomies are not warranted.

In closing, I should like to say that there is hope for the hypertensive patient, and that a physician with an optimistic outlook who does not tell the patient that he has hypertension with a capital H and is willing to work along with the day to day problems, is likely to be pleasantly surprised. Many hypertensive patients do extremely well with conservative

guidance, and today many now in the early phases of the disorder will perhaps be fortunate enough to be maintained in relative good health until more specific and rational therapeutic measures are found.

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CAREER INCENTIVES BILL PASSES SENATE, NEARS ENACTMENT

THE AMA Washington Letter, No. 84-69

April 20, 1956

The Defense Department's bill to attract more career medical and dental officers as the bottom of the barrel is reached in the present doctor draft has passed the Senate and, after ironing out a few differences with the House version, will be ready for signature of the President. As amended by the Senate Armed Services Committee, the measure (H.R. 9428) differs from the House bill in one major respect: it makes the first \$50-a-month pay increase effective after two years of service instead of three. The other increases remain the same: another \$50 after six years and a third \$50 after 10 years' service. These increases would be in addition to continuing the \$100 a month equalization pay now given all doctors going on active duty.

Senate Committee reasoning on the change to two years for the first increase: "The required period of service under doctor draft law is two years, and more than 90% of the physicians return to civilian life at the end of the two-year period. The Committee was of the opinion that a greater number of physicians might remain in military service if the first increase were authorized at the time when the greatest number normally return to civilian life." The American Medical Association had advocated the two-year effective date for somewhat the same reasons.

The Committee noted that the pool of physicians under the doctor draft who are not obligated under the regular draft is rapidly being exhausted and therefore "the only other method for meeting the medical needs of the armed forces is to increase the size of the career Medical Corps."

NOTE: While it is expected that the present doctor draft act will be allowed to expire July 1, 1957, the Department of Defense contemplates asking for an amendment to the regular draft. The amendment would provide for a special registration of physicians and dentists, and their selective call up to age 35. The extent to which special calls would be made would depend on the growth of the regular medical corps.

Reports

COMMITTEE FOR THE STUDY OF PELVIC CANCER*

BEVERLEY C. COMPTON, M.D., *Secretary*

The Committee meets on the third Thursday of each month, October-June, in the Small Hall of the Medical and Chirurgical Faculty Building. Selected cases are presented for discussion. All physicians are invited to attend the meetings.

Abstracts of Case Discussions:

1. M. H. White. Age: 41 years. Married. Gravida 3. Patient says that menses have been profuse for many years but this markedly increased in the year before coming to the hospital, with periods prolonged to two weeks. Patient consulted doctor A several times regarding the excessive bleeding. She says that pelvic examination was not made but she was told that she was in the menopause and given medicine to control the bleeding. On December 7, 1955, patient says that she had a "hemorrhage." She consulted doctor A a few days later—was not examined. About mid-December, she consulted doctor B—pelvic examination made. The patient says that a "test" was taken and sent for diagnosis, and a repeat "test" on January 20. In January and February, the patient had very profuse periods with passage of large clots and slight bleeding between periods. She remained under care of doctor B—treated with injections to control the bleeding. She was referred to the hospital clinic in early March 1956, and was immediately hospitalized for a D. & C. and biopsy.

Diagnosis: Adenocarcinoma, fundus, grade II, with extension to the cervix.

Treatment: Radium. The patient is to be re-admitted for evaluation before decision as to further treatment—a modified Wertheim or deep x-ray therapy.

Chairman: Is there any comment on this case?

We have a letter from doctor A. He was unable to be here today but sent us the following information:

"This patient was first seen by me on May 31, 1952, for a history of menorrhagia. At this time, I gave her Diethylstilbestrol 5 mgm. four times a day. She was told if she was not improved, to have a D. & C. done. Pelvic and speculum examinations were negative.

The next time this patient was seen was on December 22, 1952, for history of menorrhagia for the preceding three

weeks. Again, this patient was told to have a D. & C. done to determine the cause of menorrhagia.

In July 1955, this patient came in complaining of bleeding for the past ten days. I gave her Testosterone Propionate 50 mgm. and Estrogenic hormone 25,000 units plus Blitene Chloride Sulfate 100 mgm. twice a day. Again this patient was told to have a D. & C. because of the repeated periods of bleeding. At that time, her blood pressure was 240/100.

She was seen again on December 9, 1955, with a history of excessive bleeding. She had come in at that time for hypertension. She refused a pelvic or speculum examination at that time but promised to come back in one week. Again it was impressed on her that with a history of bleeding excessively for the past two years, a D. & C. should be done."

You will notice that this is a different story than the one given by the patient. There are often differences in the history as given by the patient and in that received from the physician, and I am sure we have to expect this more or less.

My own feeling is that this patient should have had a D. & C. or she should not have received treatment. If the patient received treatment that relieved the symptoms even temporarily, it could have encouraged her to put off any further investigation or treatment.

Committee member: I think that is the crux of the situation. To treat a patient with injections to control bleeding, without a D. & C. to establish the diagnosis, is wrong treatment.

Committee member: As has been said here many times, there will always be patients who want to delay or not follow the prescribed treatment, but there are ways and ways of persuading them to follow advice.

Chairman: It seems that there was some delay here. Doctor B also followed the patient for two or three months before she was sent to the hospital clinic. Do we have any further information as to what type of "test" was taken in December and in January?

Visiting surgeon: The "tests" were Papanicolaou smears and were reported as negative. I urged the patient to have a D. & C. but she thought she might need an operation later and did not want to use up her Blue Cross. After the second report was negative, I decided to send her to the hospital clinic

* Under the auspices of the Medical and Chirurgical Faculty and the Maryland Division of the American Cancer Society.

Committee member: The patient has now had two applications of radium and has done very well. She is a very obese woman, with hypertension and some signs of decompensation were present when she entered the hospital. The house staff thought that she was such a poor surgical risk that the D. & C. and radium applications were done under a local. She is considerably better now—the signs of decompensation have cleared up and the E.K.G. is all right. We put her on a diet and she has lost considerable weight.

Committee member: From a technical standpoint, why a Wertheim when you thought her a poor risk for a D. & C.?

Committee member: We will have her come in for evaluation before we undertake this. She is much improved but we shall have the medical staff pass on her before any surgery. If possible, I think surgery is the best treatment in this case. This would be a modified Wertheim, not a radical Wertheim.

Chairman: How many feel that there was delay in this case on the part of the physicians?

Committee member: According to the "rules of the game" as we have established them, I don't think we have any choice. We have said that a lapse of time of more than a month in establishing the diagnosis is "delay"—whether or not criticism is implied. There was a loss of time of considerably more than a month in this case.

(It was agreed that the case should be classified, *Patient and Physician Delay.*)

2. E. G. Colored. Age: 44 years. Married. Gravida 6, Para 5. Patient says that periods were regular to November 1955, although somewhat prolonged for several months previously. A normal period in early November. November 14th, a profuse hemorrhage—patient taken to hospital accident room by ambulance. She was given several injections to check the bleeding and then sent home. Patient says that she was told that she was in the menopause and was having an episode of "heavy menstruation." (Hospital record notes "Impression: Incomplete abortion.") The bleeding stopped but the patient consulted Doctor A a few days later because of weakness and shortness of breath. She was treated with iron, injections, and other medication. She says that pelvic examination was not made because of recent examination at hospital. Some intermenstrual bleeding in December and two episodes of postcoital bleeding. Patient continued under care of doctor A—referred to specialist in mid-January. Hospitalization was immediately advised and patient was admitted to the hospital on January 30th.

Diagnosis: Epidermoid carcinoma, cervix, international classification, stage IV.

Treatment: Deep x-ray therapy and radium.

Chairman: This looks like a bad one. It is hard to believe that the patient was examined at the time she was seen in the accident room of the first hospital, and the disease not detected. If she was not examined, it is bad; if she was examined, it is just that much worse to have missed such an extensive cervical cancer.

Committee member: When we saw this patient in February, she had a vesico-vaginal fistula. The carcinoma was very extensive—out to the pelvic wall on both sides. Of course, she was seen at the first hospital in mid-November and we did not see her until February. She must have been at least a stage three in November.

Chairman: According to the patient, doctor A did not examine her because of the recent examination at the hospital. This accounted for further delay in the case. I am sorry we do not have any further information from this physician.

Visiting surgeon: Is this a case of "improper or inadequate treatment?"

Chairman: No, I believe we have reserved that classification for cases in which the diagnosis was not made. The delay here was in making the diagnosis.

3. L. S. White. Age: 29 years. Married. Gravida 2 0 0 2. Menses said to be normal. Some slight vaginal discharge for several years. No abnormal bleeding. October 1955, intermittent pain in right and left iliac region. Consulted doctor A and was referred to doctor B for pelvic check-up. Patient was hospitalized for a D. & C. and biopsy on November 19. Pathological report: "Extensive atypical metaplasia and carcinoma-in-situ, cervix, with deep gland penetration. No definite invasive carcinoma but the process is so extensive and shows such atypicality that invasive carcinoma can not be ruled out." A cold conization was done on November 22nd. Pathological report: "Carcinoma-in-situ with penetration into the lumina of endo-cervical glands. Serial blocking and sectioning technique shows no evidence of invasive carcinoma."

Diagnosis: Carcinoma-in-situ, cervix.

Treatment: Total hysterectomy. Ovaries and tubes not removed because of patient's age.

Chairman: There is no criticism in this case. Certainly every effort was made to establish the diagnosis. There is always some difference of opinion as to whether it is wise to leave the ovaries

and tubes in these cases of carcinoma-in-situ of the cervix. I do not know that I have ever left both ovaries, but I think it is safe. We have left one ovary in many cases and there have been no recurrences. I think the most important thing is to take a large vaginal cuff.

Visiting surgeon: How do you determine how much vaginal cuff to take?

Chairman: It depends pretty much on how fat the patient is. Whenever possible I take a good deep cuff.

Visiting surgeon: How do you feel about painting the cervix and vagina with Lugol's solution and letting that be your guide?

Chairman: I think it is a very good idea.

Visiting surgeon: I have been doing this routinely and I feel that it is a good thing. I have been amazed at what shows up in tissue that looks normal.

Visiting surgeon: I agree that it is a good routine—otherwise you are using guess work.

Committee member: Paul Young does a Schiller test on all of his patients and varies the operative procedure according to the findings.

Chairman: Yes, but he sometimes does a less extensive operation than we do. I do not think we should ever do less, and sometimes more.

Hospital Resident: May I ask one question? Would you explain just what is meant by a "modified Wertheim"—the operation you usually do for a carcinoma-in-situ of the cervix?

Chairman: I will explain as well as I can. It is a term that some people argue about. Wertheim first started with lymphadenectomy in his operation for carcinoma. But toward the end of his career he decided that gland dissection did no good. So the operation he used in the latter part of his career was about the operation we do today for carcinoma-in-situ. First, we put catheters into both ureters. Then, in addition to the usual operative procedure for a complete hysterectomy and bilateral salpingo-oophorectomy, we take two centimeters of parametria on either side and about two centimeters of upper vagina. The thing that I think is most important about this, is taking a large vaginal cuff. Although carcinoma-in-situ is confined to the surface it can be very extensively spread out.

4. A. B. White. Age: 65 years. Widow. Gravida 0. Menopause in 1941. November 1953, the patient had a total abdominal hysterectomy and bilateral salpingo-oophorectomy because of myoma. The pathological diagnosis: "Adenocarcinoma of the uterus, infiltrating type; papillary cystadenoma, benign, ovary; chronic cervicitis with mucous cysts." The patient had a course of deep x-ray therapy post-operatively. She was under the care of doctor A at this time. Patient said to be asymptomatic until January 1955, when she began to have intermittent vaginal spotting. She consulted doctor A—had two x-ray treatments at hospital. The spotting continued. Beginning in July 1955, bleeding increased in amount and at times was fairly profuse. Late November 1955, patient referred to third hospital for evaluation.

Diagnosis: Adenocarcinoma of the fundus, post-operative with metastasis to vagina.

Treatment: Radium.

Chairman: We can't say that there was delay in this case. Finding carcinoma in a removed specimen is something that has happened to almost all of us. However, the diagnosis would have been established by a pre-operative D. & C. and it appears that such was indicated in this case.

Is there anyone who has anything to say about this case?

Committee member: This patient was seen in our clinic in November 1955. At this time the situation was pretty hopeless. The extension involved the bladder. We have given her some palliative radium.

According to our history, the operation in November of 1953 was performed because of myoma and menometrorrhagia. There was no pre-operative D. & C.

Chairman: Yes, we have information from doctor A, received by telephone, that the patient had fibroids and was having bleeding. Although fibroids were present, the post-menopausal bleeding was an indication for a diagnostic D. & C.

Committee member: Had the diagnosis been established, the patient would best have been treated by intracavitary radium before surgery.

Chairman: We have discussed that question here a good many times. There is some difference of opinion over the country, but it has certainly been the opinion of this Committee and those present at the meetings that adenocarcinoma of the fundus is best treated with preoperative intracavitary radium.

Since we have used this procedure in our clinic, the incidence of vaginal recurrences has been very markedly reduced.

Statistics

Cases to May 1, 1956.....	1213
Classification:	
No delay.....	394
Asymptomatic detected cases.....	34

Patient delay.....	514
Physician delay.....	100
Physician and patient delay.....	75
Institutional delay.....	31
Institutional and patient delay.....	26
Institutional and physician delay.....	5
Institution, physician and patient delay.....	2
Inadequate or improper treatment.....	12
Delay due to laboratory error.....	2
Unclassified to date.....	18

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ARTICLES OF INTEREST

HAVE WE REACHED THE END OF THE CULTURAL PERIOD IN MEDICINE?*

AMOS R. KOONTZ

In his presidential address before the American Surgical Association in 1952, Dr. Daniel C. Elkin² of Atlanta made an eloquent plea for the study of the humanities in the making of a doctor. I believe that Dr. Elkin's eloquent address struck a responsive chord in almost every member of the organization. It was most timely, and should be given far more than lip service. Certainly, though, we ought to keep on talking about it, and, if we talk enough about it, maybe we will eventually get something done about it. The medical profession has made great progress scientifically but has lost ground culturally. This is undoubtedly a result of the time in which we are living.

Spengler in his "The Decline of the West" defines the civilization of any period as the outcome of the culture of which that civilization is in one sense the final phase. He states that every culture has its own civilization: "The Civilization is the inevitable destiny of the Culture." . . . "Civilizations are the most external and artificial states of which a species of developed humanity is capable. They are a conclusion, the thing-become succeeding the thing-becoming, death following life, rigidity following expansion, intellectual age and the stone-built, petrifying world-city following mother-earth and the spiritual childhood of Doric and Gothic. They are an end, irrevocable, yet by inward necessity reached again and again."

In the classical period Spengler speaks of the Romans as the successors of the Greeks—Roman Civilization ended Greek Culture. The Greek

soul was followed by the Roman intellect. This is the differentiation between Culture and Civilization.

Spengler times the period of transition from Culture to Civilization in the Classical world in the fourth century B.C., and for the Western world in the nineteenth century, only just ended. If, as Spengler suggests, a civilization marks the end of a culture and the end of a world phase, the outlook for us is not bright.

In the present century there have been many evidences in medicine of change from a cultural phase to one of civilization. Many of the old ideals have been sacrificed for "practical" gains. The soul has been in abeyance and the intellect foremost. The professors of forty or fifty years ago were men, not only well versed in the medical subjects which they taught, but they were also thoroughly familiar with the humanities, and this latter familiarity greatly enriched their lectures. In those days one never heard of pre-medical courses. Now pre-medical courses are being so stressed that the youngster about to study medicine thinks only of them and forgets all about his general education. Culture has been sacrificed for Civilization. Can we recapture the soul of the old culture? In my opinion, it is well worth trying.

What has made the difference between now and several decades ago? Possibly the competition for places in medical schools has made students in college put all of their time on subjects allied to medicine, thus sacrificing the humanities. Of course medicine has become vastly more complex and the very complexities of it are so absorbing, that, unless doctors have,

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early in life, developed an interest in cultural subjects, these subjects are very apt to be neglected in the busy hurly-burly of medical practice.

Every day examples illustrating our cultural decline are present everywhere in the number of uppercrust doctors who murder the King's English, especially with regard to the pronunciation of terms, both lay and medical. When I was in medical school, I never heard one of my teachers mispronounce the word "s-y-n-d-r-o-m-e." It was invariably pronounced syn'-drō-mē. Now one frequently hears, even distinguished professors, call it syn-drōme. This has been going on so long that now some of our dictionaries give the latter pronunciation as the correct one. Thus does language deteriorate. Many examples of mispronunciation of common medical terms have been given before^{1, 2}, and they could be multiplied endlessly here. Many doctors today have never had even "a little Latin and less Greek," have never been exposed to either, but even so, pride in the Mother Tongue should make them keep a dictionary close at hand so as to get the proper pronunciation of the terms which they use daily, even if they do not understand the derivation of those terms. If one is going to say syn-drōme, why not say sys-tōle also, as they are both from the same type of Greek words.

I recently heard a well known surgeon use the correct and incorrect pronunciation of the word "duodenum" alternately during the course of a talk. In one breath he would use the correct pronunciation—du-o-dē'-num; and, in the next breath, the incorrect one—du-ōd'-e-num. Such orthoëpic gymnastics completely distract the discriminating audience from the content of the paper. One often hears he-men urologists completely emasculate one of the terms most often used by them by calling u-rē'-ter, ur'e-ter. Also, the practice of using the long ū seems to be going out of fashion even with highly educated people. It is bad enough to hear ignorant radio announcers speaking of tōones for tūnes, and to

hear news broadcasters talking about the nōos, but it really hurts to hear educated and important doctors speaking of stōo-dents, tōo-mors, and tōobes.

Recently at the Annual Meeting of The Johns Hopkins Chapter of the Phi Beta Kappa Society, I heard learned professors speaking of the "constitōotion" of the society and of the "stōo-dents" who were being initiated.

At the last meeting of the American Surgical Association I heard eminent surgeons mispronounce the names of such medical celebrities as Billroth and Heidenhain. I also heard equally prominent surgeons speaking of "expiriments" for "experiments" and calling a "stomach" a "stom-ik." To what depths can we descend anyway?

Have we so soon after Osler's death forgotten the teachings of that great man? It was he³ who admonished us that: "In no profession does culture count for so much as in medicine, and no man needs it more than the general practitioner, working among all sorts and conditions of men, many of whom are influenced quite as much by his general ability, which they can appreciate, as by his learning of which they have no measure. The wider and freer a man's general education the better practitioner is he likely to be, particularly among the higher classes to whom the reassurance and sympathy of a cultivated gentleman of the type of Eryximachus, may mean much more than pills and potions."

That our Culture is deteriorating, there can be little question. Maybe Spengler had the right answer, and we are passing through an inevitable phase. If so, what are some of the factors in that inevitability? I believe that one factor is the degeneration of our educational system. That this system has deteriorated, is shown by the fact that we now have a great many snap elective courses, both in secondary schools and colleges—institutions in which in the old days the courses were exclusively "solid meat" courses, into which one could get one's teeth and derive

intellectual sustenance. The philosopher John Dewey, who thrived in the early part of this century, has been blamed for the deterioration in our educational system. He made the obvious observation that one does best what one likes best to do. Well, of course, any third grade schoolchild knows that, and it does not take a profound philosopher to make it known to the world. However, certain educators perverted Dewey's dictum and made it say that students shouldn't be required to study those subjects which they did not like. This resulted in the so-called Progressive Education of today, which lays almost all of its stress on the method of teaching and entirely too little on the content. It doesn't make very much difference, according to their practice, whether a teacher knows very much about his subject or not, as long as he has taken a lot of courses in how to teach it. This has resulted in taking the soundness out of education, and in substituting for a great many of the old time "meaty" courses, courses which consist of nothing but utter tripe. Thus, in one of the leading teachers colleges in the country (Columbia) the following is the title of one of the courses offered*: "Social, Psychological and Economic Foundations for the Enriched Teaching of Textiles and Clothing." All of the teachers' colleges with which I am familiar offer courses in such similar bunk. Is it any wonder, then, that our teachers and our teaching have deteriorated, or that we are losing our cultural values? Think also of the many courses in physical education and home economics which are given in both our secondary schools and colleges. Students are even allowed to major for degrees in these so-called educational subjects. One should not forget either the so-called social sciences, which may be social, but are certainly not science. How different from the days when the liberal arts courses consisted of the humanities and the real sciences!

In one of our leading state universities recently the number of masters degrees conferred in Education was suddenly quadrupled.

The reason was that the State Board of Education had ruled that the salary of any teacher getting a masters degree in Education would be automatically increased. Think of how much better it would have been for the students (our future citizens) if the reward to the teachers had been given for getting a masters degree in the subject they were teaching, instead of in methods of how to teach it.

Teachers, like poets, are born, not made. The first requirement of a teacher is that he know his subject. Certainly he cannot teach it unless he does know it. Multiplying courses in methods will not enhance his knowledge of his subject. I know that many of our best teachers are unwilling victims of this system and resent having to take a lot of unnecessary and useless courses in order to secure advancement, or increase in salary.

And what of the people who take Doctor's degrees in this so-called Education, which is really educational hocus-pocus? They are the people who hold professorships in our teachers colleges and act as superintendents of public instruction. They control, and water down, our educational system all along the line. Most of them get Ph.D. degrees. However, some of our universities, not wishing to allow the Ph.D. degree to sink so deep in the mire, save their consciences by giving instead the Doctor of Education (Ed.D.) degree. This degree has no language requirement as does a Ph.D. degree and therefore consists entirely of courses in Hocus-Pocus (alias Education). A course in chiropody has more "meat" in it than such doctors' degrees, and yet teachers are promoted not on the basis of what they know but on the basis of how many courses they have taken in this educational flim-flam. What chance has Culture against the onslaught of Progressive Education?

In seeking the causes of the obvious decline in cultural tendencies, one must not neglect the type of political philosophy which has dominated our country for the last couple of decades, and

which has afflicted some other countries, such as, for instance, Great Britain and some of her dominions, for an even longer period of time, and to a far greater degree. Any political setup which inhibits thrift and incentive is bound to have a demoralizing effect on the peoples concerned. It discourages work, and work is certainly in some way bound up with moral values. One cannot live in a completely socialistic country any length of time without realizing that the people are doing just as little as they can to "get by." Their moral values have gone. Even doctors work only five days a week and become indifferent to the welfare of their patients. They let them wait for weeks and months for appointments for consultations in urgent conditions. They are indifferent and careless about emergency cases, often even refusing to see them. Osler⁶ once said that "the master-word is Work." That is still true, although many people no longer practice it. Osler, besides being a great doctor, was one of the most cultured men of his age. He did not get that way without work. Work is what made our country the greatest country in the world. Our country did not become great by people working short hours and having a poor sense of moral values. It became great by thousands of citizens, in all walks of life everywhere, burning the midnight oil and working hours "above and beyond the call of

the duty," in order to gain objectives, which helped, not only them, but their fellow citizens as well. Moral values were involved, as they are in every Culture. They were predominant in the ancient Classical Culture, and unless we can regain them here, we cannot regain our Culture; and even our Civilization, as the terminal phase of that Culture, will degenerate into a fellah-system such as terminated the Civilizations in Egypt, India, and China.

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Special Article

PLANNED PARENTHOOD CLINIC*

This report is intended to bring the physicians of Maryland up-to-date on the progress of Planned Parenthood in Baltimore since its inception as a purely medical experiment in 1927. The Bureau for Contraceptive Advice had been the outcome of three years of study by a Committee composed of members of the faculties of the School of Hygiene and Public Health and the School of Medicine of The Johns Hopkins University, as well as a group of Baltimore citizens interested in social betterment. Among the outstanding physicians who served on this Committee from 1926 through 1932 were Drs. J. Whitridge Williams, Raymond Pearl, William Howell, Ross McC. Chapman, Donald R. Hooker, Mildred C. Clough, Paul W. Clough, Adolf Meyer, L. Wardlaw Miles, Mary Sherwood, Lillian Welsh. Dr. Bessie L. Moses was appointed the first Medical Director, and continued to serve in this capacity until 1956. Dr. Frances H. Trimble has recently been appointed to succeed Dr. Moses.

The initial plan was to collect 1000 case histories of married women referred for health reasons only. It was stipulated that these referrals be through a physician who did not himself feel qualified to give contraceptive advice. On November 2, 1927, the Bureau received its first patient, who had been referred by a physician because he felt that further pregnancies would impair her health or endanger her life. The plan of the Committee was to study the results and assess the efficacy of the treatments in these 1000 cases. In October 1932, when 1152 patients had been treated, the case histories were studied by Drs. Williams and Pearl. In his report Dr. Pearl stated:

"It is a matter of great gratification that the scientific character and standards of the work of the Bureau have produced so favorable an impression upon the officers of the Milbank Memorial Fund in New York City as to lead them, during the past year, to put at the disposal of the Bureau

substantial financial aid, particularly for the purpose of helping in following up patients for a sufficient length of time so that adequate judgment might be formed as to the effectiveness of the contraceptive methods advised."

When the original Committee had completed its objective, the clinic was regarded as no longer being on an experimental basis. It was reorganized as a functioning clinic under the name of the Baltimore Birth Control Clinic, with most of the original Committee members remaining still active. Still occupying the same clinic building at 1028 North Broadway which had been given to the original Committee by Dr. and Mrs. Donald R. Hooker, the Baltimore Birth Control Clinic continued to treat married women who could not afford the services of a private physician. As the patient load grew, more physicians were added to the staff and a training program for physicians was instituted.

In 1942, along with the growth of a national organization and the establishment of hundreds of such clinics throughout the country, there was a growing awareness on the part of the public in general of the necessity for such medical services. Therefore a reinterpretation of the phrase 'birth control' was felt necessary, since child spacing and not family limitation was the chief aim of the national and local organizations. As a result of this change of emphasis, many of the clinics and the national organization changed the name to Planned Parenthood, the exceptions being the few organizations which were and still are known as Maternal Health Centers.

At this stage in 1942 the Planned Parenthood organizations enlarged the scope of their activities to include infertility studies on childless couples, education for marriage, and marriage counseling. The Planned Parenthood Clinic started the first Fertility Clinic in Baltimore, which is still actively functioning, and pre-marital and marriage counseling is given on request. In 1937, at the instigation of interested community leaders, a branch clinic was opened in Ellicott City, which was closed during the war years due to lack of space; these patients were

* Compiled and edited by Mrs. Virginia Costine, *Executive Director*, Bessie Moses, M.D., *Former Director*, and Frances Trimble, M.D., *Director*.

transferred to the clinic on Broadway. In 1938, again at the request of community leaders, a branch clinic was opened in Northwest Baltimore for the Negro community.

The Baltimore clinic's only limitation in accepting patients is that they be married women, living with their husbands, who cannot afford the services of a private physician. Patients come from all over the state and from neighboring states as well. There are only a few other child-spacing clinics under other auspices in operation in Maryland, one in Annapolis and several in Montgomery County.

The merger of the Northwest branch clinic with the parent clinic on Broadway in 1955 was the result of the study of community needs. The decision was made to relocate the main clinic and offices in a more central place and establish branch clinics in low-income areas where patients could be more easily reached. This was the reason for the purchase of the present clinic building at 352 East 25th Street. It was only fitting that this should be called the Hooker Memorial Building, in honor of Dr. and Mrs. Hooker who had given the original house at 1028 North Broadway.

Clinic sessions are now being held at 352 East 25th Street. Child-spacing clinics hours are Mondays, 10 to 12 a.m.; Tuesdays, 2 to 4 p.m.; Thursdays, 2 to 4 p.m.; Fridays, 2 to 4 p.m.; Fertility clinics on Wednesdays, 9 to 11 a.m. and 2 to 4 p.m.; Pre-marital clinic, by appointments only. Appointments are necessary in the Fertility Clinic also. A service is available for those patients who, for religious or other reasons, wish to be instructed in the Rhythm Method of child-spacing. Only new patients need make appointments in the child-spacing clinics. Patients come from all possible sources, referred by other patients, private physicians, clergymen, health agencies, welfare agencies, publicity, etc. In carrying out the new program of branch clinics, the first has been established at Lutheran Hospital Out-Patient Department, Tuesdays 10 to 12 a.m.

During the 29 years the Planned Parenthood Association of Baltimore, Inc. has been operating continuous health services in the community of Baltimore and the State of Maryland, over 25,000 individual women or couples have been treated.

352 East 25th Street
Baltimore 18, Maryland

ARTHRITIS AND RHEUMATISM FOUNDATION

Subject to approval by Congress of Public Health Service Funds, a proposed research fellowship program has been announced by the National Institutes of Health to begin July 1, 1956. This program, while designed to foster additional research in the pre-clinical sciences, is also aimed at increasing the number of trained men available for teaching in both pre-clinical and clinical fields.

Applicants must apply through their medical school, dental school or school of Public Health. Salaries for the fellows are up to \$10,000 annually. An additional amount up to \$2,000 is given for partial research expenses.

The research fellow would be assured of five years of support provided the Congress continues annually to appropriate the necessary funds for each year.

Additional information may be obtained from "Division of Research Grants, National Institutes of Health, Bethesda 14, Maryland."

Component Medical Societies



ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.
Journal Representative

STAFF OF THE MINERS HOSPITAL,
FROSTBURG, MARYLAND

At a recent meeting held at the home of Dr. Hilda Jane Walters, Frostburg, Maryland, Dr. Leslie E. Daugherty, Cumberland, Md. addressed the staff, on "History of Medicine in Western Maryland."

The Miners Hospital, built as a fifty bed hospital in 1913, by a State grant of twenty-five thousand dollars, with five thousand dollars annual maintenance; now has sixty-two beds.

A State Institution; consideration is being given to turn it over to a responsible group in Frostburg, for local operation. It has served its usefulness as a State Institution.

Other members serving on the active staff are; Doctors John B. Davis, John C. Devers, W. E. Gattens, W. O. McLane, Hilda Jane Walters, Frostburg, Md. and Dr. Leslie Miles, Lonaconing, Md. and Dr. Ruth Peachy, Grantsville, Md.

DR. WOODWARD ADDRESSES COUNTY MEDICAL SOCIETY

Dr. Theodore E. Woodward, Professor of Medicine, at the University of Maryland and Physician-in-Chief, University Hospital, addressed the Alleghany-Garrett County Medical Society on May 24, at the Fort Cumberland Hotel, Cumberland, Md. His subject was "Choosing the Right Antibiotic."

PERSONALS

Dr. Thomas Robinson has given up his practice in Cumberland and removed to Muncie, Indiana, where he will be associated with the Muncie Clinic.

Dr. Robinson located in Cumberland, after graduating from Johns Hopkins and served an internship at Cleveland Clinic and his residency at the University of Michigan.

His practice was limited to Pediatrics.

Dr. Carleton Brinsfield, has been appointed as Plant Surgeon to the Pittsburg Plate Glass Company. This company is constructing a forty-three-million-dollar plate glass plant, in Cumberland, Md. Glass will be made in its entirety from the raw sand to finished plate glass.



Miners Hospital Staff Officers

Dr. H. C. Diehl, *President*; Dr. Martin M. Rothstein, *Secretary*; and Dr. F. T. Harratt, *Vice-President*.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

STUART M. CHRISTHILF, JR., M.D.

Journal Representative

The annual Spring meeting of the Obstetrical and Gynecological Society of Maryland was held in Annapolis, Thursday, May 17.

A round of entertainment starting with luncheon at 1:30 and including a cocktail party in the afternoon was provided at the Annapolis Country Club. Golf and swimming were made available to the members of the Society before the luncheon and later after the scientific session. The business meeting was held at 2:30 and was followed by an excellent scientific session.

The facilities at the Anne Arundel General Hospital and the Naval Academy Hospital were opened throughout the day for inspection for those who might be interested. A tour of historic Annapolis entertained the ladies during the afternoon.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

Prior to its April meeting, the Executive Board briefed the City Delegates with respect to the forthcoming meeting of the Faculty. Policies that the Board had taken traditionally regarding matters of the moment were reported and, occasionally, defended. The Delegates then organized and discussed their own attitudes on forthcoming legislation.

At the Executive Board Meeting that followed, a number of policy matters *not* concerned with insurance were taken up. First was the problem of emergency care for patients when they cannot get to their own doctors or their own doctors cannot get to them. Dr. Samuel Morrison wrote that it often was difficult for doctors to leave a full office and get to the homes of patients where emergencies had occurred. At the same time, physicians in the patient's vicinity were reluctant to give care to the patient of another doctor. Dr. Morrison advocated that doctors be reassured about seeing patients under such circumstances and about practical understanding of mutual problems being expressed by willingness to help each other. Such a step he thought would promote better public relations with the laity as well. The Board turned this matter over to the Committee on Emergency Medical Calls, Dr. John M. Scott, chairman, for consideration.

A letter from a member of the Baltimore City Council, Mr. William D. Schaefer, Fifth District, called attention to an ordinance he had introduced to require mandatory collection of trash and garbage twice weekly irrespective of holidays. He pointed out that if the regular collection day in an area fell on a holiday, no collection was made until the next regular day. Garbage was allowed to accumulate sometimes for a whole week so that it became a health hazard and rat nuisance. He requested the support of the Baltimore City Medical Society in this matter. The Executive Board heartily endorsed the Resolution and offered assistance in any way that might be of help. The President, Dr. Grant Ward, was directed to appoint a committee to study the City sanitation problem and work with Mr. Schaefer.

Dr. Whitmer Firor brought to the attention of the Board that grievance matters dealing with members

of the City Society were being taken directly to the Faculty Grievance Committee, without being screened by the City Society. It is State Society policy that these matters should first be handled if possible at the local level. Several County Societies had requested that they be allowed to deal with their own problems and seek help from the Faculty only when unable to resolve the problem on their own doorstep. Dr. Firor pointed out that the Council had expressed the opinion that Baltimore City Society should do likewise and obviously were not aware that the Executive Board is *also* the Grievance Committee of the City Society. The secretary, Dr. John Classen, was directed to write a letter to the Council to request that any Grievance case dealing with a member of the Baltimore City Medical Society be handled at the local level prior to any consideration at the State level.

Of interest to our Baltimore Medical community were the ceremonies in honor of Dr. Hugh R. Spencer, retiring Professor of Pathology at the University of Maryland Medical School on April twenty-eighth. The day long program included a reception of friends and former students in the Pathology Building; a Seminar and luncheon in the University Hospital; and a banquet at a downtown hotel. The April Number of the "Bulletin of the School of Medicine of the University of Maryland" was dedicated to Dr. Spencer in special, white covered copies distributed at the Dinner. Doctors Albert E. Goldstein, C. Reid Edwards, and Walter D. Wise spoke in turn about Dr. Spencer and his career in Maryland and at the Medical School. They praised him as an effective administrator, sincere scientist, and inspiring teacher. Many gifts were presented to him by admirers and a volume of felicitatory messages was bound and given him.

Contributions from former students made possible the painting of his portrait. At the unveiling of the fine picture, the artist, Mr. Stanislav Rembski, epitomized the regard we all have for Dr. Spencer. The portraitist spoke of the delight he had in getting to know his subject while the painting progressed. He claimed that of all his subjects he had never known one with such '*integrity of spirit*' as he found in Dr. Spencer. The portrait was presented to the Medical School and accepted in the name of the University by Dean William S. Stone. Donations from his friends will be used to establish a scholarship at the

School. In this way Dr. Spencer continues to be a friend to all who know him and will be one in years to come to many who may not have had that privilege.

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

Journal Representative

The regular April meeting was held on the 17th at the Francis Scott Key Hotel. The speaker of the evening was Dr. Dale Jenkins, entomologist at Fort Detrick. He gave an informative and interesting talk on the role of insects as disease carriers and pests.

Dr. James M. Goodman, aged 82, died April 22. He had practiced here for 51 years during which time he had been at intervals City and County Health

Officer. He was a singularly sweet person, much beloved by all who knew him.

HOSPITAL EVENTS

The Hospital Staff meeting was held on the 2nd. Three cases of death with jaundice as an outstanding symptom were presented. The first by Dr. Chase was acute infectious hepatitis, the second by Dr. Pearre, was carcinoma of the head of the pancreas and the third by Dr. B. O. Thomas was of carcinoma of the common bile duct.

The department of Medicine, Pediatrics and Obstetrics had a joint meeting on the 16. Dr. Harry Gray spoke on "Diabetes Delivery" and Dr. Heldrich spoke on "Diabetes in the Newborn."

The case presented at the April Clinical Pathological Conference was that of an enormous subdural hematoma in an epileptic chronic alcoholic.

DESIRABLE LOCATION FOR PHYSICIAN

Dorchester County

The area of Fishing Creek and Hoopersville in lower Dorchester County has recently mourned the death of their only physician, Dr. James Meade, who practiced actively there for the past forty-eight years.

This is an area rich in tradition where the main source of livelihood is the water. Wild fowl abound in the winter season and the remainder of the year is devoted to oystering, fishing and crabbing.

The nearest physician is in Cambridge, some 30 miles away, where there is a well-equipped 70 bed hospital. It is both difficult and time consuming for the patient to travel to Cambridge or the physician to travel to the patient. The general area of practice includes some 3,000 persons. A qualified physician would encounter no difficulty in obtaining hospital privileges. There has been a Citizens Committee established in the area to interview any prospects and to assist in any way possible for an interested physician who would like to practice there. Contact Dr. Alfred R. Maryanov, Cambridge, Journal Representative, Dorchester County Medical Society.

Necrology*

Grover C. Ney, M.D.

1886 - 1956

Dr. Grover C. Ney was born in Harrisonburg, Virginia on February 9, 1886. He received his primary education in the schools of his home town, then entered Mt. St. Joseph's College in Baltimore where he completed his premedical education. He then entered The Johns Hopkins Medical School where he received his M.D. degree at the age of twenty-two years, in 1908. After his graduation, he received an appointment of an internship in the Hebrew Hospital, now known as the Sinai, where he served as a house officer for a period of four years, two of which service was as Medical Superintendent. It may be stated that all services in the Hebrew Hospital were, at that time, grouped under one management, viz., the "Medical Superintendent."

After completing his four years at the Hebrew Hospital Dr. Ney decided to venture into the private practice of surgery, for which specialty he received his training under such masters as J. M. T. Finney, Thomas Cullen, John Chambers, and many other outstanding surgeons of the period. Because of his ability it was not long before he enjoyed an extensive practice in his chosen field.

To make his life complete Dr. Ney married an attractive young widow, the former Selma Strouse.

Besides having been one of the attending surgeons on the Sinai Hospital Staff Dr. Ney was a member of the Baltimore City Medical Society, the Medical and Chirurgical Faculty of Maryland, and was a charter member of the American College of Surgeons.

*Memor Committee: A. S. Chalfant, M.D., *Chairman*, John F. Hogan, M.D. and Robert H. Riley, M.D.

Though his interests extended into many fields, his God, his family and his patients were of paramount importance to him.

He died of coronary thrombosis and pulmonary edema on April 12, 1956. Surviving him are his widow, a son, two brothers and two sisters, and many devoted friends who with his devoted family will mourn his passing.

BENJAMIN KADER, M.D.

Elijah E. Nichols, M.D.

1886-1956

It is with deep regret that we note here the passing on April 6 of Dr. Elijah E. Nichols, a greatly respected physician for 44 years in Pikesville. Dr. Nichols at the time of his death was 70, and had been in declining health for several years. He leaves behind him a wonderful record of service that began after his graduation from the University of Maryland Medical School in 1911. Those who knew him well confirm the opinion one gets from his many grateful patients that he gave of his time, energy, and skill most unselfishly through the decades, always answering the call for help at any time without question. His record of zero maternal mortality in over two thousand deliveries is especially noteworthy as evidence of his achievements in the medical sphere. No less important, however, is the fact that he gave of himself most conscientiously to the duties of being a good citizen of his community, busying himself in local civic and political affairs through the years.

Dr. Nichols will be missed, but never forgotten, by all who knew him.

DONALD L. SOMERVILLE, M.D.

Health Departments

STATE DEPARTMENT OF HEALTH

Drownings in Maryland

In the last five years 683 Maryland residents drowned. Every one of these drownings could have been prevented! According to these figures we anticipate that an additional 136 persons will lose their lives by drowning during 1956.

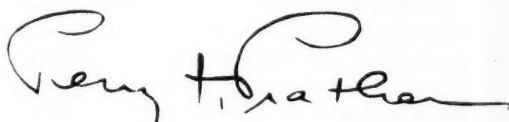
A vigorous and concentrated educational campaign should help to prevent this needless loss of life. Through its Home Accident Prevention Unit the Maryland State Department of Health has instigated such a program. With the help of Health Officers literature and posters were distributed throughout the counties of Maryland and Baltimore City. Press releases and radio spot announcements regarding water safety were prepared and disseminated. Television broadcasts included showings of films from the American Red Cross, the Outboard Boating Club of America and the Aetna Life Insurance Company. An illustrated pamphlet on Water Safety was prepared in collaboration with the American Red Cross. In cooperation with the University of Maryland Extension Service a Short Course for Swimming Pool Operators and Managers was conducted. Films, literature, and posters were made available to individuals interested in water safety programs. Much of this work was directed toward Scout activities, summer camps and schools. However, there is still need for additional efforts.

In 1955, 31 drowning accidents in Maryland involved boating. (These figures do not include the 14 drownings which occurred with the sinking of the schooner, *Marvel*.) Pleasure boaters and sport fishermen need to take more precautions in the selection and use of equipment; to heed unfavorable weather conditions so they are less apt to get caught in a storm; to learn greater skill in handling boats; to

have on hand, and to use, buoyant cushions or life jackets. They must be taught what to do when a boat overturns and be helped to develop the judgment which will enable them to respond sensibly in emergencies. Undoubtedly many accidents are the result of panic.

As in boat handling an increased knowledge and greater skill will help to reduce drownings from swimming. Those who like the water and who frequent beaches or pools often learn to swim well enough for increased enjoyment. If their instruction is informal, they may fail to learn certain safe practices. One of these is that every swimmer should familiarize himself with possible hazards such as obstructions under the water, sudden step-offs, shallow spots too near the diving area, bad undertow or strong currents. A swimmer should also know his own limitations and abide by them. Above all, there should be universal observation of the other standard rules: Never swim alone, never swim immediately after eating, never swim when overtired or overheated, and in case of a drowning start artificial respiration at once.

A physician's help in disseminating information regarding water safety can be of great value. His teaching will carry more weight with his patients than statements from any other source. Educational material regarding safe boating and safe swimming is available to physicians who may want to use it in their offices.



Director

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, June 1-28, 1956

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIO MYELITIS, PARALYTIC	POLIO MYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total 4 weeks																			
Local areas																			
Baltimore County	19	—	44	—	55	—	46	—	—	1	5	1	—	1	19	—	4	p-1	4
Anne Arundel	16	—	8	1	26	—	21	—	1	—	—	1	—	—	2	1	—	m-1	1
Howard	2	—	—	—	2	—	4	—	—	—	—	—	—	—	1	1	2	—	—
Harford	1	—	—	—	44	—	8	1	—	—	1	—	—	—	2	—	3	—	—
Carroll	1	—	4	—	20	—	15	—	—	—	—	—	—	—	2	—	—	—	1
Frederick	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3	—	4
Washington	9	—	—	1	1	—	—	—	—	—	—	—	—	—	2	—	3	m-1	—
Allegany	—	—	—	—	1	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Garrett	—	—	1	—	2	—	—	—	—	—	—	—	—	—	—	—	3	m-1	—
Montgomery	23	—	16	—	35	1	36	—	—	3	—	2	—	—	3	—	5	—	1
Prince George's	10	—	8	1	57	—	23	—	1	—	9	—	—	—	13	—	—	m-1	1
Calvert	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Charles	—	—	—	—	2	—	10	—	—	1	—	—	—	—	—	—	—	—	—
Saint Mary's	5	—	1	—	21	—	1	—	—	—	—	—	—	—	1	—	—	—	—
Cecil	—	—	—	—	5	1	—	—	1	1	1	—	—	—	2	—	1	m-1	1
Kent	—	—	—	—	31	1	7	—	—	—	1	—	—	—	2	—	—	—	—
Queen Anne's	—	—	—	—	—	—	2	—	—	—	—	—	—	—	—	—	1	—	—
Caroline	1	—	1	—	11	—	3	—	—	—	1	—	—	—	—	—	4	—	—
Talbot	—	—	1	—	5	—	5	—	—	1	—	—	—	—	1	—	6	—	—
Dorchester	—	—	—	—	—	—	—	—	—	—	—	—	—	—	6	—	2	—	1
Wicomico	5	—	4	3	38	—	2	—	—	—	—	—	—	—	2	—	5	—	1
Worcester	1	—	1	—	8	—	2	—	—	—	—	—	—	—	1	—	—	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	5	1	—	—	—
Total Counties	93	0	89	6	364	3	180	6	3	4	21	2	2	1	66	3	42	—	15
Baltimore City	104	0	100	5	96	3	148	0	0	0	18	0	0	6	96	16	573	e-3	19
State																			
June 1-28, 1956	197	0	189	11	460	6	328	6	3	4	39	2	2	7	162	19	615	—	34
Same period 1955	119	5	45	29	196	2	134	11	2	4	77	0	0	28	173	17	642	—	24
5-year median	239	1	78	34	620	3	238	2	—	6	80	3	2	31	209	14	556	—	24
Cumulative totals																			
State																			
Year 1956 to date	2316	0	977	66	9030	36	2243	7	3	6	606	8	2	81	1090	152	3262	—	413
Same period 1955	2007	8	406	221	1315	19	1275	26	5	10	2099	3	0	225	1028	187	3563	—	354
5-year median	2923	10	610	253	4890	44	1715	13	—	9	1291	13	11	228	1261	106	3384	—	368

e = encephalitis.

m = meningitis, other than meningococcus.

p = psittacosis.

Ancillary News

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Executive Secretary,*
Maryland State Nurses Association

PROGRAMS IN TUBERCULOSIS NURSING IN MARYLAND

Programs of instruction and supervised practice in tuberculosis nursing for students of basic schools of nursing are offered currently by three tuberculosis hospitals in Maryland—Glenn Dale, Baltimore City, and Mt. Wilson.

Glenn Dale Hospital, although located in Glenn Dale, Maryland, is administered by the Department of Public Health of the District of Columbia. The tuberculosis nursing program, approved by the District of Columbia Board of Examiners of Nurses, is open to basic baccalaureate students only and covers a period of six weeks. Currently four colleges are participating in the Glenn Dale program.

The Tuberculosis Division of the Baltimore City Hospitals, Baltimore, and Mt. Wilson State Hospital, Mt. Wilson, conduct eight weeks' programs approved by the Maryland State Board of Examiners of Nurses. Beginning in September 1956 the program at Mt. Wilson will be shortened to six weeks. The program at Baltimore City Hospitals is available also to graduate nurses who desire to increase their knowledge and skills in tuberculosis nursing. On request, a program of work experience for graduate nurses is planned at Mt. Wilson State

Hospital to meet the special needs and interests of the individual nurse.

These programs in tuberculosis nursing are directed generally toward providing the student with a fundamental knowledge of tuberculosis in all its aspects, developing her ability to apply the principles of general nursing to the special needs of tuberculosis patients, and increasing her understanding of public health implications and community programs for care of tuberculosis patients and control of the disease. This experience also gives the student an opportunity to observe and participate in a program of patient care which utilizes community resources to restore and rehabilitate the patient to maximum function.

The instructional plan embraces organized theory, observations, conferences, seminars, field visits, and supervised practice in a variety of selected nursing situations. In addition to medical and nursing staff, personnel from many departments of the hospitals and from allied agencies participate in the instruction.

Schools of nursing and graduate nurses interested in these nursing programs may secure further information from the directors of nursing of the respective hospitals.

Book Reviews*

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them.

Anesthesia: Thief of Pain. Sylvan M. Shane, D.D.S. Vantage Press, Inc., New York. Copyright, 1956. 87 pages. \$2.50.

This book is intended for the lay reader and is patterned after the writings of Paul de Kruif and the *LADIES HOME JOURNAL*. The author attempts to explain the phenomenon of anesthesia and the use of certain of the anesthetic agents. There are chapters describing the use of ether, pentothal, cyclopropane and regional anesthesia, with a lively description of the sensations experienced by the patient during the induction of these anesthetics.

In conception the idea of the book is sound but the reviewer is not sure the delivery is as smooth as it might be. In the introduction it is stated "... it should be given to intelligent patients as a part of their preparation for an operation." This reviewer is not sure. The book is a curious mixture of dogmatism, enthusiasm, excellent description, flippancy and undefined medical words. The dogmatism affronts the physician, the flippancy is in questionable taste (the surgeon in one instance is referred to as I. Kilem Tighbelly; amusing perhaps to the anesthesiologist) and the medical words confusing to the lay reader for whom the book is intended.

Writing for the lay reader is always a difficult task since a certain amount of dogmatism is necessary, but the medical profession is then with the problem of the patient demanding a certain technique or drug because "Dr. X said in his book. . ." The author seems to have ignored the truism of anesthesia that the agent used is not so important as the person administering it. Thus there will be some objections raised by the anesthesiologist regarding the indications broached by the author as specific for one anesthetic agent in contrast to another. Another objection is the lack of emphasis on the prime function of the anesthesiologist; that of supportive care during surgery and the immediate post-operative period.

In conclusion, this reviewer feels that the pre-operative visit and discussion by the anesthesiologist can be individually tailored to meet the requirements of each patient in a manner far better suited to his emotional

needs. There is no substitute for the sympathetic, personal touch in any physician-patient relationship and the practice of anesthesiology is no exception to this.

P. R. H.

Practical Therapeutics. Martin Emil Rehfuss, M.D., F.A.C.P., LL.D. (Hon.) Professor of Clinical Medicine, Emeritus, and the Director of the Division of Therapeutics, Department of Medicine, Jefferson Medical College, Philadelphia and Alison Howe Price, A.B., M.D., Associate Professor of Medicine, Jefferson Medical College, Philadelphia. Williams and Wilkins Company, Baltimore, Publishers. Copyright, 1956. Third Edition. 972 pages. Illustrated. \$15.00.

This rather imposing text represents the efforts of the authors and a number of contributors to present the changing field of modern therapeutics in a manner satisfactory to both the busy practitioner and the medical student. The book is actually an outgrowth of the course in general therapeutics conducted at the Jefferson Medical College. The enthusiasm of the medical profession for practical therapeutics may be estimated from the fact that the current volume represents the second revision since the initial edition of 1948.

In general, one would assume that such a difficult subject as is represented by the ever changing scope of medical therapeutics would be entirely too ambitious a project to be successfully presented in a bound form. Undoubtedly, this is true in many instances. However, if one considers the present publication in the light in which it is written, that of a basic reference for therapeutic procedures to which the busy physician can turn for information as needed, the real value of the book can be appreciated. The necessity for frequent revisions of the subject material is obvious.

In the five years that have elapsed since the second edition, many newer therapeutic procedures have appeared and the authors have made an attempt to present such changes in general as well as in specific instances where established. Basically, the text is well written by men of established reputation in the field of therapeutics and the subjects are discussed in a pleasing and readable outline form. The book is arranged into four large sections headed: I—General Therapeutic Principles, II—Symptomatic Therapy, III—Treatment of Specific Disorders, and IV—Special Treatment.

* The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

The section dealing with General Therapeutic Principles is of special value. Included are sub-sections devoted to such things as prescription writing, dietary therapy, nursing problems of interest to the physician as well as a special section entitled, "Contents of the Physician's Bag." Section II—Symptomatic Therapy, has many interesting and useful features which should appeal to all branches of the medical profession. A particularly welcome addition to this section has been an outline entitled "Suggested Diagnostic Procedures in the Study of Cryptogenic Fever." The third major section is concerned with the Treatment of Specific Disorders and discusses them by systems. This section has been extensively revised in the third edition and with a few exceptions is outstanding. The majority of more common ailments are included with the unfortunate omission of those involving the nervous system. The fourth and last section, Special Treatment, acts as a coordinator for the preceding sections and attempts to include features that may have been omitted or less thoroughly presented previously. Included are sub-sections devoted to: the antibiotics, steroid therapy, industrial therapeutics, and an expanded and up-to-date section devoted to the use of radioisotopes in medicine.

The subject matter is enhanced by numerous tables, graphs, and eye-catching, informative, color and black-and-white illustrations. These features in addition to a fair bibliography add to the value of *Practical Therapeutics* as a general reference. It is not difficult to recommend it as a worthwhile addition to the physician's library.

J. B. W.

Preventive Medicine in World War II. Volume II. Editor-in-Chief Colonel John Boyd Coates, Jr., MC. Editor for Preventive Medicine, Ebbe Curtis Hoff, Ph.D., M.D., Office of the Surgeon General, Department of the Army. Washington D.C., Publishers. Copyright 1955. 404 pages.

This volume is one of the series on the role of the Medical Department of the United States Army in Preventive Medicine in World War II and deals specifically with environmental hygiene. It is an historical record of the problems of hygiene and sanitation and tells how these problems were met in World War II.

It is not presented as a text on these subjects. It is an account of what was done and not what should be done. The rapid mobilization and widespread employment of our armed forces made the scope of this problem global, and emphasis is placed on problems in various parts of the world. Accomplishments and failures are recorded in actual happenings.

This volume consists of 404 pages. The contents are in nine chapters under the following headings:

- I. Food Management
- II. Housing
- III. Water Purification
- IV. Waste Disposal
- V. Control of Insects
- VI. Rodent Control
- VII. Research Background of Insect and Rodent Control
- VIII. Foreign Quarantine
- IX. Preventive Medicine in Ports of Embarkation and for Persons in Transit

The following quotation from the Foreword by Major General George E. Armstrong, the Surgeon General, is appropriate in the review of this book: "Credit and gratitude are due the authors not only for contributing these chapters but also, in many instances, for establishing the sound framework upon which future management of environmental hygiene within the Army may be based."

In reading this book and in recalling experiences in this field, one is deeply impressed by the initiative and resourcefulness of the members of our Armed Forces as individuals and as integrated teams. Their ability to "find how" in solving new and difficult problems recorded in these chapters was characteristic of our people and a credit to our nation.

Among the many individuals mentioned in this volume for outstanding contributions, it is of interest to note a quotation from the Introduction by General James Stevens Simmons citing the "able and distinguished leadership" provided by Colonel William S. Stone as Director of the Division of Sanitation during the early part of the war and later, as Chief of Preventive Medicine in North Africa and Italy.

It is also of interest to note in the account of the development of the use of DDT the following statement: "In an effort to reduce fly and mosquito incidence in Manila after its capture, that city was sprayed several times from the air, under supervision of Colonel M. C. Pincoffs, Acting City Health Officer. . ."

S. E. M.

The Truth about Cancer. Charles S. Cameron, M.D. Copyright 1956. Prentice-Hall, Inc., New York, New York, Publishers. 268 pages. Illustrated, \$4.95.

At the present time there is an organized attack on cancer from two directions. The first concerns itself with fundamental and applied research by which it is hoped that new weapons and methods of therapy will be produced far more satisfactory than any that are now possessed. The other attack attempts to reduce

the interval between the onset of the disease and its treatment by current methods of therapy.

In "The Truth About Cancer," Dr. Cameron has provided, for the layman, a comprehensive and authoritative survey of the present status of these attacks. While careful to underline the limitations of present day knowledge of cancer he, nevertheless, points out that science has constantly made interesting and important discoveries which are useful in our every day efforts to control the disease. Dr. Cameron has a knack of presenting complicated scientific facts in an acceptable way to the layman with an average background.

The second half of the book takes up various types of cancer and reviews information which should be useful to an individual who wishes to inform himself about the disease in a manner which would be helpful to him and his family. A special effort is made to explain common misconceptions that have been preserved by word of mouth.

"The Truth About Cancer" is a well balanced presentation of the fascinating and mysterious problem of cancer and it should prove helpful to the general reader who might be interested in this matter.

H. W. J., JR.

SENATE GROUP APPROVES 'LITTLE' OMNIBUS BILL

The AMA Washington Letter, No. 84-74

Drawing on three titles of the administration's omnibus health bill of last year, a health subcommittee has drafted and the full Senate Labor Committee has endorsed a five-point health measure. Chairman Lister Hill (D., Ala.) is hopeful of early action by the Senate. The bill authorizes the following:

1. Traineeships for graduate or specialized training in public health for physicians, engineers, nurses and other professional public health personnel.
2. Traineeships for nurses to teach or to serve in administrative or supervisory jobs.
3. Grants to states for practical nurses and other auxiliary personnel under the U. S. Office of Education.
4. State grants for personnel training and research projects in improving mental health techniques.
5. Extension for two years beyond July 1, 1957 of the Hill-Burton hospital-clinic building program.

Only in point 3, practical nurse training, does the bill specify a sum—\$5 million a year over a 5-year period. In connection with the mental health grants title in the bill, a similar measure (H.R. 9048) has been approved by the House Interstate Committee and is awaiting House floor action. Proponents of Hill-Burton extension point out that because of the long-range planning required under this program, it is necessary that any extension be made at least a year in advance of expiration of the act.



Woman's Auxiliary Medical and Chirurgical Faculty



MRS. GERALD W. LEVAN, *Auxiliary Editor*

MARYLAND ANNUAL REPORT

MRS. GERALD W. LEVAN

The Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland is completing its sixth year of activity with a growth in membership and accomplishment. As president, I am pleased to submit the following report for 1955-1956.

Organization: Despite the relentless efforts of our chairmen, we were not successful in adding another county auxiliary this year. However, we have increased our membership more than twenty-seven per cent and have erased all but two red dots from the auxiliary-wise map of Maryland. Total membership now numbers 571, which included forty-nine members-at-large and seventeen associate members.

Program: The national program material was sent to all county auxiliaries, with emphasis placed on public relations, nurse recruitment, mental health, legislation, civil defense and A.M.E.F. An average of four general and four board meetings was held by each county auxiliary, and programs varied widely according to the needs and interest of each individual group. The president spoke at four county meetings, reviewing and acquainting the membership with the overall program, including new features added. The most outstanding programs reported were those having lectures, films, and book reviews dealing with health subjects, civil defense, nurse recruitment, allied careers, safety, and mental health.

Doctors' Day was observed by each county, with social occasions; radio and newspaper publicity; announcements from church pulpits and in church bulletins; gifts of red carnations to the doctors; floral tributes placed in hospitals in memory of the deceased doctors of the community; furnishings for the Doctors' Lounge in the hospital; and contributions to A.M.E.F. in honor of the county medical society.

Public Relations: A survey of the county auxiliary reports shows that the individual member has

served her community well and given many hours of service to various health organizations, such as, Red Cross, Cancer Society, Tuberculosis Association, Heart Fund Campaign, Diabetic Detection Clinic, Bloodmobile, Cerebral Palsy, and other health drives. Many hours are given in volunteer services in hospitals, health exhibits at county fairs, and assuming responsibility of keeping a hospital medical library up to date. One county auxiliary observed National Hospital Week by giving a birthday party for all babies born in the local hospital during May of the previous year, with special favor shown those who were born on Florence Nightingale's birthday. This project proved so successful that popular demand necessitates a repeat for this year. Our public relations chairman has completed a survey of "Who's Who in the A.M.A. Auxiliary" in Maryland.

Nurse Recruitment: The progress of this program has been most gratifying. All component auxiliaries have scholarship and student loan funds and have been instrumental in influencing other organizations to establish like funds. Baltimore City auxiliary used their \$500 fund this year to aid a senior medical student, thus making it possible for him to graduate. The state auxiliary sponsors the Future Nurses Clubs of Maryland, which now number sixty-three with a membership of 3,000 girls in the high schools of the state. These clubs are chartered, published monthly newsletter—"Candlelight Express"—and hold an annual convention, at which the presiding officer is the auxiliary president-elect. As a project the past year, the Future Nurses of Maryland contributed \$25 to the Auxiliary for our A.M.E.F. Fund, and gave \$25 to The League for Nursing for the Korean Nurses Fund. All this in appreciation of the assistance we have given their organization. A most commendable gesture! In carrying out our nurse recruitment program, we have full cooperation of the Maryland League for Nursing, Maryland State Nurses Association, and Maryland Association of State Hospital Auxiliary.

American Medical Education Foundation: Repeated reminders about this worthy project have yielded good dividends. All component auxiliaries have contributed to this fund and the total for the year is \$404.

Bulletin: Only sixty subscribers from a membership of 571 leaves much to be desired here! We continually stress the importance of every officer and chairman subscribing to this helpful publication. How to interest the general membership is a problem which we hope to solve eventually.

Today's Health: With 141 subscriptions, Maryland has a long way to go before our quota for this authentic medical publication is reached.

Mental Health: Our interest in this important field has shown encouraging growth this year, and all component auxiliaries have a mental health chairman and have had at least one program on mental illnesses. Many books and current periodicals have been contributed to the mental institutions of the state. The state auxiliary has endorsed the Maryland Association for Mental Hygiene program for Mental Health Week 1956.

Civil Defense: Participation in this project is done on the local level. One county auxiliary sends a representative to the monthly county meetings, and takes an active part in Casualty Station work.

Legislation: Our state legislation chairman was on the job and alerted the membership on medico-economic legislation, which resulted in the members sending cards and letters to their Congressmen and to Senator Harry F. Byrd, Chairman, Senate Finance Committee, giving our reasons for opposing pending legislation.

Publications: We are allotted space in the MARYLAND STATE MEDICAL JOURNAL in ten of the monthly issues, in which the president's message and county auxiliary articles appear. Our immediate past president serves as auxiliary editor to the JOURNAL. During the year, the president sent out personal letters to new members, county presidents, and state officers and chairmen. A newsletter to all doctors' wives is in the planning stage for the coming year.

Revisions: A step forward this year has been the revision of our Constitution and By-Laws, and the committee is now busy compiling a handbook for officers and chairmen.

Maryland auxiliary is represented on the national level by two past presidents: Mrs. George H. Yeager is Regional Chairman of Civil Defense, and Mrs. Charles H. Williams is Regional Assistant to the Fifth Vice President of the national auxiliary. Mrs. D. Delmas Caples is a member of the National Advisory Council of Future Nurses Clubs. Also, we have members on Southern's auxiliary roster of officers and chairmen: Mrs. Owen H. Binkley is the Maryland Councilor for 1955-57; Mrs. Ernest Poole and Mrs. James Kerr are members of the Membership Promotion Committee; and Mrs. Gerald W. LeVan is the Doctors' Day Chairman.

Since April 1955, the president has visited all five component auxiliaries; presided at five executive board meetings and the semi-annual general meeting, and will be the presiding officer at the annual convention in May; presided at the 1955 Convention of Future Nurses, and attended two of their executive meetings; attended the National Convention in Atlantic City and gave the state report; appeared before the Medical and Chirurgical Faculty's House of Delegates meeting and spoke on "The Component Auxiliaries and Their Activities;" represented the auxiliary at the New Jersey and West Virginia State Conventions; was invited to attend the AMA Regional Legislative Conference held in New York City, in October, and when I could not go, my Parliamentarian, Mrs. Albert E. Goldstein very ably represented Maryland auxiliary. In November, the president and president-elect attended the Chicago Conference and the president spoke on "School Health;" and, in March, we were guests of Pennsylvania Auxiliary at their Mid-Year Conference in Harrisburg.

Our special guests for the annual state convention were Mrs. Mason G. Lawson, president of the National Auxiliary, and Mrs. John J. O'Connell, president of Southern's auxiliary. Their very presence inspired us, and their informational messages gave us new encouragement and enthusiasm.

REPORT ON SPECIAL ASSESSMENT**Medical and Chirurgical Faculty**

The resolution, passed by the House of Delegates at the Annual Meeting approved a special assessment for the year 1956, provided a mail poll showed the majority of the Component Societies gave their approval. The resolution further stated that the vote of the Component Societies must be in the hands of the Faculty Secretary on or before June 15, 1956, and that failure to answer would be assumed to indicate approval.

Eleven Component Societies approved the assessment, five disapproved, and seven did not reply, and the Executive Committee, therefore, considered that eighteen of the Components favored the assessment.

Members will, therefore, receive an assessment bill, as authorized under the resolution of the House of Delegates that all active members of the Baltimore City Medical Society will be assessed twenty dollars (\$20.00), and the County Society members will be assessed fifteen dollars (\$15.00).

MAKE YOUR PLANS

to attend

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in Ocean City, Maryland

FRIDAY, SEPTEMBER 21, 1956

Medical and Chirurgical Faculty

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